STATE OF LOUISIANA

Louisiana Department of Health Medicaid Managed Care Organizations

2.5 Business Proposal, 2.6 Technical Proposal, 1.44 & 4.4 Veteran and Hudson Initiative Programs Participation

REDACTED COPY

RFP Number: 3000017417

United Healthcare Community Plan

Document Contains Confidential Proprietary or Trade Secret Information

"The data contained in pages _____of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions."

The following is a list of items that have been marked confidential throughout our proposal:

Page Number	Section Title	Question/Attachment Number
Pg. 3	Cover Letter	2.4.1
Att. Pg. 16, 33, 35, 45, 47-49, 74-77, 81-88, 92-98, 131-140 152-156, 161-165	Material Subcontractors	Att. 2.5.4.3 Subcontractor United Behavioral Health Contract and Amendments
Att. Pg. 28, 109	Material Subcontractors	Att. 2.5.4.3 Subcontractor March Vision Contract and Amendments
Att. Pg. 20, 42, 47, 75, 90, 95, 128, 162, 173	Material Subcontractors	Att. 2.5.4.3 Subcontractor DBP Contract and Amendments
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Pg. 1	Written Litigation Statement	Att. 2.5.6.3a
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United Healthcare Community Plan

Louisiana Medicaid Managed Care Organizations

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3838 North Causeway Boulevard
Suite 2500
Metairie, LA 70002

September 3, 2021

Ali Bagbey
Louisiana Department of Health
628 N. Fourth Street
Baton Rouge, LA 70802

Dear Ms. Bagbey:

UnitedHealthcare of Louisiana, Inc. dba United Healthcare Community Plan (UnitedHealthcare) is pleased to submit a response to the Louisiana Department of Health (LDH) Request for Proposals for Louisiana Medicaid Managed Care Organizations.

In accordance with Section 2.4.1 of RFP #: 3000017417, we provide the following information:

2.4.1 Cover Letter

2.4.1.1 Location of Proposer's administrative office with full time personnel;

3838 North Causeway Boulevard, Suite 2500
Metairie, LA 70002

2.4.1.2 Name and address of Proposer's corporate principal office registered with the Louisiana Secretary of State, email address, website URL, and telephone number;

Karl Lirette
Chief Executive Officer, Director
3838 North Causeway Boulevard, Suite 2500
Metairie, LA 70002
karl.lirette@uhc.com
www.uhccommunityplan.com
(504) 849-3523

2.4.1.3 Name and address of the Proposer's corporate principal office for the purpose of issuing checks and/or drafts;

UnitedHealthcare Community Plan
Collin McQuiddy, Chief Financial Officer
3838 North Causeway Boulevard, Suite 2500
Metairie, LA 70002

2.4.1.4 Any other name(s) under which the Proposer does, or has done within the last ten (10) years, business;

We have not used another name within the last 10 years of business.

2.4.1.5 Ownership status (whether the bidding organization is publicly traded or privately held). If privately held, a statement listing name(s) and address(es) of principal owners who hold five percent (5%) interest or more in the organization;

UnitedHealth Group Incorporated, the ultimate parent of United Healthcare of Louisiana, Inc., is a publicly traded company.

2.4.1.6 The type of legal entity (for example, corporation (profit or not for profit), limited partnership, general partnership, or trust), and the state where the entity is organized, including any parent organization;

UnitedHealthcare of Louisiana, Inc. is a for profit entity incorporated in Louisiana. UnitedHealthcare, Inc. is the parent organization of UnitedHealthcare of Louisiana, Inc. It is a for profit entity incorporated in Delaware.

2.4.1.7 If out-of-state Proposer, name and address of local representative; if none, so state;

UnitedHealthcare of Louisiana, Inc. is not an out-of-state Proposer.

2.4.1.8 If any of Proposer's planned personnel is a current Louisiana State employee, or was employed by the State of Louisiana within the past two (2) years, provide a listing to include the employee name, State agency, and termination date, if applicable;

UnitedHealthcare of Louisiana has no current or planned personnel who is a current Louisiana State employee or who was employed by the state of Louisiana within the past two years.

One of UnitedHealth Group's current employees, Dr. Alexander Billioux, was previously employed by the LDH. His termination date was Oct. 2, 2020. During the hiring process, Dr. Billioux obtained an ethics opinion from the State and has complied with all restrictions. Dr. Billioux has not had any involvement in the development of this proposal for UnitedHealthcare of Louisiana, Inc. Although Dr. Billioux does not work directly for the Louisiana Health Plan, if a contract is awarded to UnitedHealthcare of Louisiana, Inc., Dr. Billioux's team may provide support for the Louisiana Health Plan through managing relationships with the social resource referral network, and more broadly, his would support population health and health equity strategies that might have been proposed and relate to screening, referring and closing the loop on health-related social needs. Dr. Billioux's support of the Louisiana Health Plan in this capacity in the event that a contract is awarded is consistent with the guidance provided in the State's ethics opinion.

2.4.1.9 Proposer's State and federal tax identification numbers, LaGov vendor number, and Louisiana Department of Revenue number, if available;

Tax ID number: 72-1074008
LaGov vendor number: 310097820
Louisiana Department of Revenue number: 5717574001

2.4.1.10 A brief statement of the Proposer's involvement in litigation related to the delivery of Medicaid benefits in the last ten (10) years;

UnitedHealthcare of Louisiana, Inc. has not been involved in any litigation related to the delivery of Medicaid benefits in the last 10 years.

Our Approach to Serving Louisiana's Medicaid Managed Care Program

Thank you for the opportunity to share our experience and approach to serving Louisiana's Medicaid residents. For over eight years, UnitedHealthcare of Louisiana, Inc. has partnered with the residents of Louisiana and the Louisiana Department of Health (LDH) in **"Helping people live healthier lives."** As of July 2021, we serve more than 500,000 Louisiana enrollees and are the largest organically grown managed care organization (MCO) in Louisiana. Through our commitment

to enrollee health, strong brand recognition and local community partnerships, we have been **the MCO of choice** for the past eight years, with the highest **proactive choice rate and over 75% of our members self-selecting UnitedHealthcare of Louisiana in 2020**.

As the leader and chief executive officer of UnitedHealthcare of Louisiana, I am supported by Angela Olden, chief operating officer, and Julie Morial, chief medical officer. For us, Louisiana is home, and we have a deep understanding of our communities, the health care market and the challenges faced by our community, our enrollees, our providers and our staff. We are guided by a local team that drives transformation for Louisiana and are supported by a national team that curates best practices, drives scale and provides deep resources to support our local communities. We are committed to building a workforce that is reflective of the enrollees we serve. When recruiting, we first consider Louisiana residents who have qualified experience in our roles. Nearly 45% of our Medicaid enrollees in Louisiana are people of color. **Our health plan staff and key personnel leadership roles reflect these demographics** [redacted]

The Louisiana Department of Health's principles drive high-quality care and promote health to Louisianans and the Medicaid Managed Care Program. We see LDH's transformative vision, and we have worked side-by-side with LDH to pave the way to a healthier Louisiana for our enrollees and the communities in which they live. One way we support LDH's mission and priorities is through our reinvestment in Louisiana, with more than **$11 million** invested since 2018, with over **$9 million** of that reinvestment focused directly on Louisiana initiatives that further health equity.

Strategic Pillars

UnitedHealthcare's experience over the past eight years in Louisiana has given us insight into the unique perspectives of the state, our enrollees and their communities. Our strategic pillars are built on our deep understanding of LDH's Strategic Plan priorities guiding us on enabling and engaging providers, communities and enrollees to drive integrated care while improving health equity and outcomes.

UnitedHealthcare will perform to LDH's highest standards to implement continuous improvements in health care quality and safety. We will leverage our experience with the Louisiana population to deliver more efficient and effective processes that enhance member outcomes. Our proven track record of excellence and innovation will allow us to: increase MCO accountability, implement proven practices and technology to detect fraud, waste and abuse, provide high quality and transparency, closely monitor member and provider satisfaction metrics and increase network access to ensure adequacy. For example, to help build a diverse provider network and drive sustainable change that reflects the people we serve, we are establishing a new four-year, $50,000 scholarship program with LSU Medical School for Black in-state students. This is part of our efforts to leverage relationships such as our CMO Dr. Julie Morial's position on the LSU National Diversity Board to encourage youth of color to pursue studies in medicine.

Advancing health equity is the foundation of our population health approach. We are committed to building a program that is more reflective and supportive of the membership we serve. We have designed our population health model to identify and address priority areas for subpopulations based upon disparity analyses using stratified data and the nationally validated Area Deprivation Index. For example, we reviewed data on more than 55,000 Louisiana enrollees with hypertension and found our Black enrollees are 1.4 times more likely to have hypertension than white enrollees. We are working with several providers who serve 7,000 of our Black enrollees on an evidence-based "Tuck-in" program to address this disparity. Enrollees receive weekly 1:1 outreach from a PCP office

care coordinator to check their vitals, medication adherence, diet and exercise and connects them to services and supports. One provider's initial results found that enrollees experienced a 42% drop in emergency department use and a 72% drop in inpatient hospitalization after engaging in the "Tuck-in" program.

To enhance our enrollees' well-being and quality of life, UnitedHealthcare is committed to seamless, effective and efficient health care that is reflective of whole-person health needs. From preventive care through end-of-life care, we strive to provide a health care continuum for our enrollees that addresses physical, behavioral and social determinants of health needs in a fully integrated manner. For example, in August 2018, we provided a $1.2 million grant to Woman's Hospital to implement its Guiding Recovery and Creating Empowerment (GRACE) program for pregnant enrollees who have a substance use disorder. GRACE provides comprehensive case management and care planning from providers in obstetrics and addictive disorders. Enrollees in the program receive a warm handoff to resources, including addiction recovery treatment centers, MAT and social services support. This has resulted in increased MAT uptake, 90% of participating individuals being connected to behavioral health counseling, a 50% decrease in preterm births and an average1.35-pound increase in birth weights.

To address Louisiana's specific health care needs, we collaborate with community partners to develop innovative solutions that address the community's specific needs. For example, we analyzed data from LDH on COVID-19 vaccinations by race/ethnicity and found a statistically significant Index of Disparity, with the lowest rate among white enrollees, particularly in the northern part of the state. Recognizing that some vaccine hesitancy is related to religious views, we partnered with the Catholic Diocese in Shreveport and the Greater Zion Baptist Church to conduct vaccination outreach and education. We understand and embrace the role we can play to bring all stakeholders in the health care system together by enabling community organizations. We will continue to look for opportunities to evolve our relationships with community partners by bringing innovative solutions and critical investments to bear on priority issues of the State and local communities. We know that these local partnerships are a necessary catalyst for transforming Louisiana's health care system.

UnitedHealthcare is reimagining health care through the lens of our enrollees in Louisiana. We are using this perspective to support our providers in transforming and delivering better health care experiences and outcomes. For example, we are initiating an Integrated Shared Savings model with the Louisiana Primary Care Association. Providers with an integrated medical and behavioral health clinical model that meet targeted quality measures can share in savings they achieve against a blended total cost of care (TCOC) metric. Because the TCOC metric includes both medical and behavioral health utilization, it will strengthen integration and holistically improve quality.

UnitedHealthcare looks forward to a continued partnership with LDH to build on our commitment to transform Louisiana residents' lives by achieving better health and lower costs. If you have questions or require clarification regarding our proposal, please do not hesitate to contact me.

Sincerely,

Karl Lirette
Health Plan CEO, UnitedHealthcare Community Plan
(504) 849-3523
karl.lirette@uhc.com

2.5 Business Proposal [5-page limit]

2.5.1 Mandatory Qualifications

In order to be considered for award, the Proposer must demonstrate that it has met the following mandatory…

2.5.1.1 Meets the federal definition of an MCO, as defined in 42 C.F.R. §438.2;

UnitedHealthcare of Louisiana, Inc. meets the federal definition of an MCO, as defined in 42 C.F.R. §438.2 in serving Medicaid enrollees.

2.5.1.2 Has the capacity and willingness to perform all functions in this RFP and in the Model Contract;

We have the capacity and are willing to perform all functions in this RFP and in the Model Contract.

2.5.1.3 Is not an excluded individual or entity as described in 42 C.F.R. §438.808(b);

We are not an excluded individual or entity as described in 42 C.F.R. §438.808(b).

2.5.1.4 Has a minimum of five (5) years of experience* as an MCO for a Medicaid managed care program prior …

UnitedHealthcare of Louisiana, Inc. has six years of experience as an MCO, which was preceded by three years participating in Louisiana's Medicaid program through a shared service contract. Together with our affiliates and nationally, we have 47 years of Medicaid and public sector experience.

2.5.1.5 Has, within the last thirty-six (36) months, been engaged in a contract or awarded a new contract as a…

In 2015, UnitedHealthcare of Louisiana, Inc. received a contract to provide prepaid Medicaid services in Louisiana and, in January 2018, received a 23-month extension. On Jan. 1, 2020, UnitedHealthcare of Louisiana, Inc. received a contract to provide Acute Care Medicaid through Dec. 31, 2020, which was later extended through an amendment to Dec. 31, 2021. From 2012 until 2015, UnitedHealthcare of Louisiana, Inc. participated in Louisiana's Medicaid program through a shared service contract prior to being awarded a full risk contract in 2015.

For the last 36 months, UnitedHealthcare has been engaged in or awarded new contracts in 31 states plus the District of Columbia. These states include Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Mississippi, North Carolina, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Washington and Wisconsin (plus the District of Columbia). Many of these states, including New York, Texas, Michigan, Arizona, Ohio, Tennessee and Kentucky, have a Medicaid managed care population equal to or greater than 1.5 million enrollees. Most recently, some of the contracts we have won include:

- **Kentucky:** Our new contract started Jan. 1, 2021, and runs through Dec. 31, 2024, which may be renewed at the completion of the initial contract period for six additional two-year periods upon the mutual agreement of the parties. Serving more than 154,000 enrollees statewide in 2021, we serve Expansion, CHIP, TANF, SSI with Medicare, and Supplemental Security Income (SSI) without Medicare.
- **North Carolina:** Our new contract started July 1, 2021, and runs through June 30, 2024, plus two optional one-year extensions (up through June 30, 2026). Serving more than 360,000 enrollees statewide, this contract provides a Medicaid program that works closely with the State to improve the overall health and well-being of North Carolina Medicaid beneficiaries enrolled with the State's Standard Medicaid and CHIP (known as North Carolina Health

Choice). The program provides whole person, coordinated care, addressing medical needs and social supports and services. Covered services include hospitalization, preventive health care, immunizations, health education, non-emergency medical transportation (NEMT), vision care, prescription drug coverage, personal care, home health care, durable medical equipment, medically necessary supplies and transplant services.

2.5.1.6 Has its principal place of business located inside the continental United States.

UnitedHealthcare of Louisiana, Inc.'s principal place of business is:
3838 N. Causeway Blvd.
Suite 2500
Metairie, Louisiana 70002

2.5.2 Conflict of Interest

Neither the Proposer nor any of its subcontractors may have any interest that will conflict, as determined by LDH…
2.5.2.1 A signed Exhibit A, *Certification Statement*, attesting that the Proposer does not have any financial, legal…
2.5.2.2 A signed Exhibit A, *Certification Statement*, attesting that the Proposer does not have, nor does any of the..
2.5.2.3 A signed Exhibit A, *Certification Statement*, attesting that the Proposer agrees to submit any additional…
2.5.2.4 A statement describing any and all of the financial, legal, contractual, and other business interests of the…

We do not anticipate any of our or our subcontractors', their affiliates, parents, subsidiaries or related organization's financial, legal, contractual and other business interests to affect or impact our performance under the contract.

2.5.2.5 Any other information that may be relevant to the Proposer's or any material subcontractor's financial,…

There is no additional information we consider relevant to the RFP and contract.

2.5.3 Moral or Religious Objections

The Proposer shall provide:

2.5.3.1 A statement of attestation that the Proposer has no moral or religious objections to providing any MCO…

UnitedHealthcare attests that we have no moral or religious objections to providing any MCO Covered Services described in the Model Contract.

2.5.3.2 A statement of any moral and religious objections to providing any MCO Covered Services. The statement…

Not applicable.

2.5.4 Material Subcontractors

Proposers may enter into subcontractor arrangements or agreements, however, shall acknowledge in their …

2.5.4.1 If the Proposer intends to subcontract for portions of the work, the Proposer shall identify any …

UnitedHealthcare has read and understood the full agreement and acknowledges total responsibility for the entire contract, including serving as the single point of contact for any subcontracted work.

2.5.4.2 The Proposer shall state whether material subcontractors will be used to provide all, or part, of any…

UnitedHealthcare is committed to providing the highest quality of care, services and support to our enrollees. While we deliver the majority of our services to our enrollees and providers through our own employees, we subcontract certain services when the subcontractor has a particular expertise and experience in furnishing those services. The following table contains the names of our affiliate

and non-affiliate material subcontractors. We include specific designations of tasks in *Exhibit B: Material Subcontractor Response Template* for each subcontractor.

Subcontractor Corporate or Legal Entity Name	Address	Telephone Number
United Behavioral Health operating under the brand name Optum Behavioral Health	425 Market Street, 14th Floor San Francisco, CA 94105	952-205-7401
Dental Benefits Provider, Inc.	6220 Old Dobbin Lane Columbia, MD 21045	443-896-0418
MARCH Vision Care Group, Inc.	6701 Center Drive West Suite 790 Los Angeles, CA 90045	310-216-2300

2.5.4.3 Where the Proposer utilizes a material subcontractor to provide behavioral health~~, pharmacy,~~ or vision ~~…~~

UnitedHealthcare has provided Exhibit B, *Material Subcontractor Response Template*, and executed contract and amendments in electronic format in lieu of hard copy for the following subcontractors. Please refer to the accompanying USB for those attachments.

- United Behavioral Health, Inc. (operating under the brand name Optum)
- Dental Benefit Providers, Inc.
- March® Vision Care Group, Incorporated.

2.5.4.4 The Proposer must submit a signed Exhibit A, *Certification Statement*, attesting that the Proposer:

2.5.4.4.1 Acknowledges it will not be relieved of any legal obligations under any contract resulting from this RFP …

2.5.4.4.2 Acknowledges that proposals to use subcontractors shall not cause any additional administrative burden …

2.5.4.4.3 Unless provided for in the contract, the Proposer shall not contract with any other party for any of the…

UnitedHealthcare has provided Exhibit A, Certification Statement, as part of this proposal.

2.5.5 Financial Condition [exempt from business proposal and total page limits]

2.5.5.1 The Proposer shall submit documentation to demonstrate to the satisfaction of LDH that the Proposer's …

2.5.5.1.1 Copies of audited financial statements for each of the last three (3) years, including at least a balance …

Please refer to Attachment 2.5.5.1.1 UnitedHealthcare of Louisiana Audited Financial Statement 2018, Attachment 2.5.5.1.1 UnitedHealthcare of Louisiana Audited Financial Statement 2019, and Attachment 2.5.5.1.1 UnitedHealthcare of Louisiana Audited Financial Statement 2020, which have all been provided on a USB drive.

We have attached financial statements for our parent organization, UnitedHealth Group, as Attachment 2.5.5.1.1 UnitedHealth Group Audited Financial Statement 2018, Attachment 2.5.5.1.1 UnitedHealth Group Audited Financial Statement 2019, and Attachment 2.5.5.1.1 UnitedHealth Group Audited Financial Statement 2020, which have all been provided on a USB drive.

~~2.5.5.1.2 A certificate from the taxing authority of the state in which the Proposer has its principal office, attesting…~~

2.5.6 Required Forms and Certifications [exempt from the hard copy and total page limits]

The Proposer shall complete and submit the forms detailed below. Electronic versions of the forms are available …

2.5.6.1 Exhibit C, Proposal Compliance Matrix.

Please refer to Attachment 2.5.6.1 Exhibit C, Proposal Compliance Matrix.

2.5.6.2 Exhibit A, *Certification Statement*. The Proposer must be registered as a vendor with the …

Please refer to Attachment 2.5.6.2 Exhibit A, Certification Statement.

2.5.6.3 Exhibit D, *Medicaid Ownership and Disclosure Form*, as Federal laws require full disclosure of …

Please refer to Attachment 2.5.6.3 Exhibit D, Medicaid Ownership and Disclosure Form, Attachment 2.5.6.3.a, Written Litigation Statement, and Attachment 2.5.6.3.b, Litigation Disclosure.

Exhibit B: Material Subcontractor Response Template

Proposer (MCO) name:
UnitedHealthcare of Louisiana, Inc.
Material subcontractor name:
United Behavioral Health, Inc., operating under the brand name Optum
Description of the Proposer's role and material subcontractor's role:
Proposer's Role: To provide high quality health care services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program, while using the most cost-effective manner and in accordance with LDH's terms and conditions. **Material Subcontractor's Role:** To provide behavioral health utilization management and care management; 24 hours a day, seven days a week integrated call center support for enrollees and providers to address routine, urgent and emergent call needs, inclusive of behavioral health crisis calls and substance use disorder helpline; behavioral health network management and development; behavioral health provider relations, including education and training; behavioral health data analytics, claims administration, fraud/waste/abuse audits, and quality and complaints management.
Explanation of why the Proposer plans to subcontract this service and/or function:
To support UnitedHealthcare of Louisiana in its mission of providing and coordinating high quality behavioral health care services statewide for Medicaid enrollees in the Louisiana Medicaid managed care program, using the most cost-effective manner and in accordance with LDH's terms and conditions. Optum brings specialized expertise and resources to support the behavioral health needs of Louisiana's Medicaid enrollees. Optum's emphasis on recovery and resiliency, innovations in service delivery and robust clinical programs help position the company as a strong partner to many different program types. UnitedHealthcare and Optum have a proven record of accomplishment with integrated Medicaid programs in 31 states and the District of Columbia, where they serve enrollees with similar needs to those enrolled in Louisiana Medicaid. **For example, to best serve Louisiana enrollees and to meet LDH's goals, Optum will:** **Advance evidence-based practices, high-value care, and service excellence,** via ongoing training, support, and access to resources, such as the Behavioral Health Toolkit for Medical Providers to advance evidence-based practices and prescribing in non-behavioral health settings. For example, Optum introduced Parent Child Integrative Therapy (PCIT) trainings to providers and led the efforts to expand the penetration of PCIT in Louisiana. Similarly, Optum's value-based contracting programs for medication-assisted treatment (MAT) will advance the use of evidence-based practices in the treatment of opioid use disorder (OUD). **Support innovation and a culture of continuous quality improvement in Louisiana**, by focusing on improving follow-up after hospitalization. Examples include educating inpatient facilities on Express Access providers and providers on the importance of Follow Up After Hospitalization (e.g., ensure call and/or face to face visits are made for enrollees within seven days of transitioning from acute psychiatric care to the community to assist with follow-up appointment adherence). Additionally, in 2020, Optum introduced Reducing Admissions with Collaborative Interventions (RACI), a multi-disciplinary approach which includes integrated staffing among behavioral health and medical. The

program is both facility and member-centric and provides a forum for generating solutions to decrease readmissions and increase community tenure.

Ensure enrollees ready access to care*,* by offering a comprehensive network, which includes diverse service delivery (e.g., face-to-face visits, tele-mental health, etc.) and using paraprofessionals (e.g., peer support specialists and community health workers, etc.). Optum's innovations, such as virtual visits (i.e., on demand, in-home tele-mental health) and Express Access (quicker behavioral care) networks increase enrollee access to services and extends the availability of specialized providers.

Improve enrollee health, by using a peer support model in Louisiana (implemented in 2016) to assist enrollees with mental health, substance use, and comorbid conditions to promote recovery through living testimony and reinforce resilience and self-management. Peer support specialists (PSS) engage enrollees who are difficult to reach, bridge the gap between provider and enrollee, assist in developing a support system, and increase community engagement. Optum is expanding its PSS program to three peers. Its "whole health peer coach" is further trained to promote behavioral health recovery with co-occurring chronic condition management. PSS performance is evaluated and measured through reduction in utilization and other quality indicators.

Optum will add a local recovery and resiliency manager to oversee the peer support program to promote recovery-oriented care in collaboration with the provider community and to promote a family/consumer perspective throughout all phases of the program.

Key positions, such as Optum's behavioral health medical director, clinical director, field-based clinicians, peer support specialists, network director and provider relations staff—live and work in Louisiana. Their local presence has helped Optum to form strong partnerships with community resources and systems of care.

Use a population health approach to maximize enrollee health, supported by health information technology, to advance health equity and address priority social determinants of health, which include housing, food insecurity, physical safety and transportation, via the use of interdisciplinary care teams through their whole person care approach. This approach promotes enrollee self-management and recovery through natural supports and resources (e.g., wellness recovery action plans, whole health tracker and an educational enrollee portal). Optum staff is an integral part of integrated rounds (i.e., behavioral-medical); to do this, UnitedHealthcare and Optum share technology and advanced analytics to identify and address the needs of enrollees.

Minimize wasteful spending, abuse, and fraud, using claims algorithms and data analytics to evaluate and monitor outpatient utilization activity by comparing expected and historical norms. Optum's "Outpatient Practice Management Analytics Program" was recognized by the State of Louisiana as a best practice—recouping over $41,000,000 in savings from 2018 through 2020.

A description of the material subcontractor's organizational experience:

United Behavioral Health, Inc. operating under the brand name of Optum

Optum is a national managed behavioral health organization serving approximately 37 million individuals, including 9.9 million Medicaid members. Optum's Medicaid membership includes those enrolled in UnitedHealthcare's integrated physical and behavioral health Medicaid and Dual Special Need Plans (D-SNP) programs, and through direct contracts with counties and states. Optum offers one of the largest behavioral health networks nationwide. Over 259,000 behavioral health providers participate in Optum's behavioral health network to deliver mental health and substance use disorder services, including 3,300 facilities at more than 7,600 locations nationwide. Optum also offers specialty sub networks including ones for autism/applied behavior analysis, Express Access, medication-assisted treatment, and telemental health.

Currently, in Louisiana, Optum offers behavioral health programs and services for various population types (e.g., commercial, DSN-P, Medicare and government funded plans), where they serve over 800,000 enrollees. Since 2015, Optum has provided integrated behavioral health services for Healthy Louisiana recipients; currently, they serve approximately 500,000 Louisiana enrollees, meeting the needs of the Medicaid population.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

We monitor and manage the performance of subcontractors through the mechanisms described below. These mechanisms facilitate our oversight of the subcontractors and allow us to evaluate performance, especially with respect to state contractual requirements. Unless otherwise noted, we use these approaches for our affiliate entities within UnitedHealth Group and nonaffiliate subcontractors:

- ***Operating Arrangements:*** The operating document incorporates a description of the required functions and service levels, the process by which we assess performance, the recourse we have if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate), and the authority of Karl Lirette and the executive team to drive change. Relationships are constructed, formalized, and managed with the consent of LDH, the subcontractor and UnitedHealthcare. LDH has the right to review and approve or disapprove all subcontracts for the services provided under this contract.
- ***Vendor Collaboration Meeting:*** As appropriate, we invite representatives from our subcontractors to our regular operations meetings, promoting understanding of how each functional area is dependent upon the success of the others. During these meetings, we provide direction for our subcontractors and verify their quality and effectiveness is sufficient to meet objectives. Local functional area business owners also report on subcontractor performance and measurements. Operations meetings include:
  - Feedback and oversight
  - Review of policies and procedures
  - Training and education
  - Monitoring of key performance indicators
  - Effective lines of communication
  - Responding to issues/escalating when necessary
- ***Joint Operating Committee (JOC):*** Our Joint Operating Committee monitors subcontractor performance monthly. An expedited meeting may be called to address critical issues in a timely manner as determined by our leadership and our subcontractor(s). The scope of the JOC includes developing compliance strategies and initiatives to support the subcontractor's performance such as:
  - Overall review of business performance
  - Assessment of key compliance/regulatory issues and risks
  - Audit planning and reporting
  - Escalation of issues, especially from local health plans
  - Review of fraud, waste, and abuse prevention efforts
  - Confirmation of monthly checks of federal and state exclusion lists
  - Response to identified issues

Membership of the JOC includes Louisiana plan leadership, national representatives and key business leads from UnitedHealthcare's Community & State (Medicaid) organization, and operational partners.

- ***Dedicated Staff:*** We designate accountable relationship owners from the Louisiana health plan in the appropriate functional area to work with specific subcontractors. The local relationship owner works with regional and national relationship owners to perform this oversight. Subcontractors may require additional attention when their responsibilities are of a critical nature or where performance warrants additional oversight. We understand that such steps are necessary for high quality, given the size of our health plan and the large number of enrollees and providers that depend on us. These staff members monitor and drive improvement in our subcontracted services.
- ***Statistics and Reports:*** Subcontractors are required to report key performance indicators on a monthly or basis. These reports allow UnitedHealthcare staff to monitor and evaluate subcontractors, as well as indicate action steps for improvements. Review of these statistics occurs in monthly and quarterly committee reviews.
- ***Collaboration Calls:*** During monthly or as appropriate collaboration calls, our CEO, COO and CMO (as needed), members of the local team meet with executives from our affiliate organizations, allowing for constant exchange of best practices, problem-solving and innovations that are working in other markets. Executives from our claim's operations, member and provider services centers, provider contracting, and other functional areas attend this meeting as needed. In addition, this dialogue allows our executive staff to provide direct feedback to our partners on their service quality and reinforce the prioritization of our Medicaid programs to promote contract compliance. UnitedHealthcare uses these overall monitoring approaches and mechanisms to identify and prioritize areas for improvement, set quantifiable goals and metrics, and communicate clear expectations. By creating a systematic approach to evaluate and improve our operations with our subcontractors, we have a process that promotes ongoing identification and remediation of operational challenges and implementation of best practices and innovations.
- ***Annual Review:*** We will conduct an annual review of the subcontractor's performance. This review will include, at a minimum, any performance concerns identified by LDH. We will provide LDH with a copy of the review and any corrective action plans developed as a result.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Regulatory Appendix Pg. 13 Section 4.7
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Base Agreement Pg. 14 Fifth Amendment Pg. 4
3	Specify the effective dates of the subcontract agreement. ***NOTE: it is the Fifth Amendment to the base agreement that added Medicaid to the base agreement. Previous amendments were not applicable to Medicaid.***	Fifth Amendment Pg. 1 Preamble Base Agreement Pg. 8 Section 7
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Regulatory Appendix Pg. 22 Section 6.3
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Regulatory Appendix Pg. 22 Section 6.3
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Regulatory Appendix Pg. 22 Section 6.3
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Regulatory Appendix Pg. 10 Section 4.4(e)
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Regulatory Appendix Pg. 23 Section 6.7
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Regulatory Appendix Pg. 23 Section 6.1

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Regulatory Appendix Pg. 1 Section 2.2
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Regulatory Appendix Pg. 18 Section 4.20
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Regulatory Appendix Pg. 5 Section 3.15
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Regulatory Appendix Pg. 19 Section 4.26
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Regulatory Appendix Pg. 2 Section 3.1(b)
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Regulatory Appendix Pg. 20 Section 4.31
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Regulatory Appendix Pg. 9 Section 4.4(a)
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Regulatory Appendix Pg. 10 Section 4.4 (d)

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Regulatory Appendix Pg. 12 Section 4.5 (e)
19	INTENTIONALLY LEFT BLANK	
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Regulatory Appendix Pg. 5 Section 3.15
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Regulatory Appendix Pg. 22 Section 6.2
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Regulatory Appendix Pg. 22 Section 6.2
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Regulatory Appendix Pg. 8 Section 3.26
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Regulatory Appendix Pg. 18 Section 4.23

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Regulatory Appendix Pg. 13 Section 4.6
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Regulatory Appendix Pg. 23 Section 6.10 Amendment 11 Pg. 3 – 8
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Regulatory Appendix Pg. 23 Section 6.10
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Regulatory Appendix Pg. 18 Section 4.23
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Regulatory Appendix Pg. 18 Section 4.23
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Regulatory Appendix Pg. 8 Section 4.1
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Regulatory Appendix Pg. 8 Section 4.2
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Regulatory Appendix Pg. 17 Section 4.18

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Regulatory Appendix Pg. 19 Section 4.28
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Regulatory Appendix Pg. 22 Section 6.3
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Regulatory Appendix Pg. 23 Section 6.8
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Regulatory Appendix Pg. 19 Section 4.27
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Regulatory Appendix Pg. 5 Section 3.15
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Regulatory Appendix Pg. 19 Section 4.24
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Regulatory Appendix Pg. 16 Section 4.13
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Regulatory Appendix Pg. 25 Section 6.14
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Regulatory Appendix Pg. 19 Section 4.23

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Regulatory Appendix Pg. 19 Section 4.29
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Regulatory Appendix Pg. 3 Section 3.3
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Regulatory Appendix Pg. 11 Section 4.5(c)

BEHAVIORAL HEALTH SERVICES AGREEMENT

This Agreement (this "Agreement"), is made as of March 01, 2012 (the "Effective Date"), by and between United Behavioral Health and its subsidiaries ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United"). For services provided on or after its Effective Date, this Agreement supersedes and replaces any and all other agreements, whether written or oral, between the parties regarding the subject matter contained herein.

WHEREAS, United issues and/or administers Benefit Plans on behalf of itself and Payors for the benefit of Members;

WHEREAS, United desires to contract with Vendor for the provision of its services; and

WHEREAS, this Agreement describes the obligations of both of the parties related to the performance of the services.

NOW THEREFORE, in consideration of the terms and conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree as follows:

SECTION 1
DEFINITIONS

The following terms shall have the meanings set forth below. Additional definitions may be set forth in the Agreement or the exhibits.

1.1 "Benefit Plan" shall mean a certificate of coverage, summary plan description, benefit plan, benefit package description or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payor is obligated to provide Member with coverage for Covered Services.

1.2 **"**CMS" shall mean The Centers for Medicare and Medicaid Services.

1.3 "Covered Services" shall mean a health care service or product for which a Member is entitled to receive coverage from a Payor, pursuant to the terms of the Member's Benefit Plan. The type of Covered Services to be provided by Vendor are specified in more detail in an Exhibit B.

1.4 "Member" shall mean a person eligible and enrolled with United to receive coverage from a Payor for Covered Services.

1.5 "Participating Provider" shall mean a licensed or otherwise appropriately qualified and credentialed health care professional or entity that has entered into a Provider Agreement with Vendor, directly or through another entity, to provide Covered Services to Members.

1.6 "Payor" shall mean United or such other entity obligated to provide reimbursement for Covered Services for the Member.

1.7 **"**Provider Agreement" shall mean an agreement between Vendor and a Participating Provider that sets forth the terms and conditions under which the Participating Provider participates in one or more of Vendor's network(s) of providers.

1.8 "Service Area" shall mean the geographic area in which United is authorized to provide Covered Services to Members.

1.9 "Services Addendum" shall mean a description of the services to be provided by Vendor attached to this Agreement as an Exhibit B. The parties may add additional Exhibits for additional services as agreed upon by the parties from time to time. Each such Exhibit shall be numbered as a series of Exhibit B (such as B1, B2, B3 and thereafter).

SECTION 2
SERVICES

2.1 Services Addendum. Vendor shall provide the services described in the Services Addendum to this Agreement.

2.2 United Control and Oversight. Vendor shall be subject to the reasonable direction of United, as it pertains to the services provided pursuant to this Agreement. United shall maintain oversight of Vendor for functions Vendor provides to, or arranges for, United, and will monitor services for quality assurance in conformity with applicable state law and other regulatory requirements as set forth in a regulatory appendix. The parties shall cooperate with and assist each other as reasonably necessary or appropriate in the performance of this Agreement.

SECTION 3
RESPONSIBILITIES AND RELATED PROVISIONS

3.1 Member Eligibility Information. At least monthly, on a date mutually acceptable to United and Vendor, United shall provide Vendor with a current list of eligible Members in an electronic format mutually agreeable to both parties. The eligibility information shall be prepared and provided to Vendor at United's expense. Vendor shall treat the information received under this Section as confidential and not distribute or furnish such information to any other person or entity, except as necessary and as permitted by law to provide or arrange for Covered Services. If United is unable to provide Vendor with a current list of eligible Members in an electronic format, the parties agree to adjust the compensation payable to Vendor pursuant to Section 11.15 should such alternative process cause Vendor to incur material additional costs. Subject to retroactive eligibility changes that may be required by a state or CMS, Vendor shall be entitled to rely on the most current eligibility information and Benefit Plan documents in its possession in providing the Covered Services, including processing claims for Covered Services, if applicable.

3.2 Retroactive Adjustments of Eligibility. Vendor acknowledges that there may be retroactive adjustments to Member eligibility. United shall use its best efforts to minimize such adjustments.

3.3 Benefit Plans. This Agreement is not intended nor shall be deemed or construed to modify the obligations of United or a Payor to Members as established under any Benefit Plan. United acknowledges that it retains the ultimate responsibility to assure delivery of all benefits required under a Benefit Plan between United and a Member.

3.4 Services Under This Agreement. The responsibilities of Vendor shall be limited as defined by the terms of this Agreement. If Vendor provides or arranges for requested additional services, United or Payor shall pay for the additional services according to Vendor's fee schedule and/or the amounts payable to Participating Providers for such services.

3.5 Responsibility for Information. United understands and agrees that Vendor is not responsible for any delay in the performance of this Agreement or for any non-performance under this Agreement if the delay or non-performance is caused or materially contributed to by United's failure to furnish any material information described in this Agreement.

3.6 New Benefit Plans and Changes to Services. United shall use commercially reasonable efforts to notify Vendor in writing at least ninety (90)days prior to any modification of an existing Benefit Plan, development of a new Benefit Plan or expansion of its Service Area. If such modification, development or expansion is a material change to Vendor's obligations under this Agreement or the pricing assumptions used in establishing rates, the parties shall negotiate to include the modification, development or expansion in this Agreement in accordance with Section 11.15.

3.7 Member Consents and/or Authorizations. United agrees to assist Vendor in obtaining any necessary Member consents or authorizations as required under state or federal law so that Vendor can receive protected health information when necessary for Vendor to perform its obligations under this Agreement.

3.8 Communication Materials and Activities. United and Vendor shall cooperate to provide and prepare Members' publications and programs regarding Covered Services available to Members, as applicable.

United shall use its best efforts to include legally required notices regarding Covered Services or other legally required communications related to Vendor in its scheduled mailings at no cost to Vendor. If United is unable to include legally required communications in its scheduled mailing, Vendor will reimburse United for actual mailing costs, not to include personnel and other internal expenses.

United shall submit communication materials to state and federal regulatory agencies for prior approval as may be required by and in accordance with applicable state and federal law and regulations.

3.9 Taxes. All fees charged by Vendor for the services provided under this Agreement are exclusive of all taxes and fees (including but not limited to, sales, use, excise, value-added, goods and services, consumption, and other similar taxes, duties or fees) now in force or enacted in the future, imposed on the transaction or performance of the services, all of which United will be responsible for and will pay in full, except for taxes based on Vendor's income (gross or net). Should any payment for Services provided by Vendor be subject to withholding tax by any state or local taxing jurisdiction, United shall reimburse Vendor for such withholding tax.

3.10 Identification Cards. United shall ensure that Members receive an identification card and that a mutually agreeable process is established for referring Members to Vendor when appropriate.

3.11 Non-Interference with Advice to Members. Nothing in this Agreement is intended to prohibit or restrict Participating Providers or other health care professionals from advising or advocating on behalf of a Member about:

(a) the Member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the Member to provide an opportunity to decide among all relevant treatment options;

(b) the risks, benefits and consequences of treatment or non-treatment; and

(c) the opportunity for the Member to refuse treatment and express preferences about future treatment decisions.

SECTION 4
PAYMENT; PAYMENT TERMS

4.1 Fee. For the services, United shall pay Vendor as set forth in each Exhibit A. To the extent that any settlement terms contained in this Agreement may not be specific enough to satisfy SSAP No. 96, the parties agree settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known.

4.2 No Incentive Payments. Vendor shall be strictly prohibited from receiving any incentive payment designed to reduce amounts of necessary medical care through (a) reduction of services or the charges thereof, (b) reduction of length of stay, or (c) utilization of alternative treatment settings.

4.3 Member Protection. Vendor and United agree that in no event, including, but not limited to (a) non-payment for Covered Services provided to Members; (b) insolvency of Vendor, United or another Payor; or (c) breach by United or Vendor of any term or condition of this Agreement or any term or condition of a Provider Agreement, shall United or Vendor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Covered Services eligible for reimbursement under the Member's Benefit Plan.

The provisions of this Section shall: (i) be construed in favor of the Member; (ii) survive the termination of this Agreement regardless of the reason for termination; and (iii) supersede any oral or written agreement, existing or subsequently entered into, between any of the parties to this Agreement or a Participating Provider and a Member or the representative of the Member if such agreement is inconsistent with this Section.

This Section shall not prohibit collection of any allowed amounts that are the Member's responsibility to pay for Covered Services to a Participating Provider in accordance with the applicable Benefit Plan. It also shall not prohibit the collection of charges for services that are not Covered Services as defined in the Benefit Plan; provided, however, that the Member has been informed of the costs for non-covered services prior to the rendering of such services and has agreed in writing to accept responsibility for payment for such services. The Member's written consent shall be in a form agreed to by the parties and in compliance with any applicable state and federal law. This provision also shall not prohibit payment for any Covered Services delivered after expiration of benefits under the relevant Benefit Plan. If requested by United, Vendor shall submit to United any Member's written acknowledgement to accept responsibility for non-Covered Services provided to him/her. Vendor shall ensure that Vendor's Provider Agreements with Participating Providers are consistent with the obligations in this Section.

This Section applies when any applicable statutes and regulations require that the Member be held harmless from any and all costs, which are the legal obligation of Vendor, United or another Payor.

SECTION 5
INFORMATION; AUDITS; BOOKS AND RECORDS

5.1 Maintaining Records. The books, accounts and records of each party shall be so maintained as to clearly and accurately disclose the transactions contemplated by this Agreement, including such accounting information as is necessary to calculate and support the amount of the payments made by United under this Agreement. All books, accounts and records shall be maintained in compliance with the applicable laws and regulations of the state in which United is domiciled and in accordance with prudent standards of insurance record keeping. Vendor shall maintain at its principal administrative office, and shall require, as applicable, Participating Providers and any subcontractors to maintain, adequate books and records of all transactions related to the services provided pursuant to this Agreement. Vendor shall maintain such books and records for ten (10) years after the date the records were created unless a different retention period is specified by applicable law or regulation, then such records shall be preserved for such period as required by applicable law or regulation.

5.2 Member Access to Records. Vendor shall, and shall require its Participating Providers to, establish and maintain procedures in accordance with applicable law and regulations to ensure, at a minimum, timely access by Members to medical records and other health information in their possession that pertains to Members.

5.3 Examination of Books and Records. Upon reasonable notice, during normal business hours and at a reasonable time and place, United or its designee shall have the right to examine any books or records of Vendor that relate to this Agreement during the term of this Agreement and for three (3) years thereafter unless otherwise required by law.

5.4 Corrective Action Plans. United shall provide Vendor with a report of any audit findings resulting from an examination within thirty (30) calendar days of the conclusion of an audit. If United notes a regulatory deficiency(ies) during the audit or otherwise notes a failure or delay in performance by Vendor, United may request Vendor to develop a corrective action plan. Upon such a request, Vendor shall prepare a corrective action plan and provide it to United for United's approval within thirty (30) calendar days of United's request. Such plan shall (a) be subject to United's approval (which shall not be unreasonably withheld); and (b) include specifics of and timelines for correcting the regulatory deficiency(ies) (which shall not exceed thirty (30) days).

United shall approve or disapprove the initial corrective action plan in a reasonable timeframe after receipt of such plan from Vendor. Vendor shall implement the approved corrective action plan within the timeframes specified therein. If the corrective action plan is not satisfactory to United or implemented to the reasonable satisfaction of United, United may terminate this Agreement pursuant to Section 7.1.

5.5 Government and Accrediting Agency Access to Records. Government and accrediting agencies which license the operation of United or Vendor shall have the right to inspect, evaluate and audit applicable records. United and Vendor are hereby authorized to release all information and records or copies of such within the possession of United or Vendor that are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to United or Vendor. These audit and inspection rights shall exist for three (3) years from the termination date of this Agreement, the date of completion of any audit, or such other period as required by law or as may be set forth in an Appendix.

5.6 Confidential Information. The parties acknowledge that in the course of performing their obligations under this Agreement, either party may learn or receive confidential and proprietary information, including, but not limited to, trade secrets, business or organizational plans, customer

lists, pricing, and underwriting information, concerning the other party or third parties to whom the other party has an obligation of confidentiality (collectively "Confidential Information"). Confidential Information shall not include information that:

(a) was rightfully in the party's possession prior to receiving Confidential Information;

(b) is currently or subsequently becomes available to the public through a source other than the receiving party;

(c) the party develops internally, without reference to the other party's Confidential Information; or

(d) the party receives from a third party on a non-confidential basis from a source, which to the best of such party's knowledge after due inquiry, is not prohibited from discussing such information by a legal, contractual or fiduciary obligation.

Each party shall take all necessary steps to provide the maximum protection to secure the other party's Confidential Information. Each party agrees to take at least such precautions to protect the other party's Confidential Information as it takes to protect its own Confidential Information. The parties shall not utilize any Confidential Information belonging to the other party without the other party's prior written consent for any purpose other than performance under this Agreement. The parties agree not to disclose Confidential Information to third parties without the express prior written consent of the party to whom the information belongs. The parties further agree that they will not disclose Confidential Information to anyone within their respective organizations other than those employees with a need to know and who have been informed of the party's obligations under this Agreement. The parties may disclose Confidential Information to their attorneys, accountants, or other agents ("Representatives"), but only if they need to know the Confidential Information as described above. The parties shall inform each Representative of the confidential and proprietary nature of the Confidential Information. Upon termination of this Agreement, a party in possession of any Confidential Information belonging to the other party shall either return such Confidential Information to the other party or destroy the Confidential Information, without retaining copies. If any Confidential Information is impossible or impracticable to return or destroy, the party holding such other party's Confidential Information shall remain bound by the terms of this section with regards to the applicable Confidential Information. Each party shall retain sole ownership of its own Confidential Information.

5.7 Required Disclosures. The confidentiality obligations described herein will not restrict any disclosure required by order of a court or any government agency. The party being ordered to disclose the information shall give prompt notice to the other party of any such order and reasonably cooperate with the other party, at the other party's request and expense, to resist such order or to obtain a protective order.

5.8 Ownership; Communications**.** Except as otherwise expressly provided for in this Agreement:

(a) Any books and records provided by United to Vendor pursuant to this Agreement, or developed or maintained by United under or related to this Agreement, shall be owned by United and are subject to the control of United.

(b) All funds and assets of Vendor are the property of Vendor, held for the benefit of Vendor and are subject to the control of Vendor.

(c) All funds and assets of United are the property of United, held for the benefit of United and are subject to the control of United; provided that United agrees to grant Vendor and its affiliates access to United's assets as necessary to perform the duties under this Agreement; or as may reasonably assist Vendor and its affiliates to perform hereunder, including without limitation to assist Vendor, in concert with other affiliated health plans, to achieve cost efficiencies on United's behalf; or as otherwise permitted by United and by applicable law. Neither this Agreement nor the performance of duties pursuant to this Agreement shall grant Vendor or its affiliates any ownership interest in United's assets used by Vendor or its affiliates pursuant to this Agreement.

(d) Each party shall retain all right, title and interest in its proprietary business information or work product that may be used in advertising or promoting Covered Services or that is related to other activities under this Agreement, including, but not limited to, trade secrets, computer software and applications, and any other proprietary business information or work product that is not available to the general public.

(e) Upon termination of this Agreement, each party will return to the other party all intellectual property and work product belonging to the other party and shall not retain copies of such data except as shall be necessary under applicable law.

Except as authorized in this Agreement, each party further agrees to obtain the other party's permission before using any of the other party's copyrighted materials in its communications materials. If either party produces its own communications materials, it shall do so at its own cost and submit materials that use the other party's trademarks, logos, copyrighted or other branding materials to describe Covered Services to the other party for prior review and approval, which shall not be unreasonably withheld or delayed. Any promotional videos may be rebroadcast and brochures made available via the parties' intranet solely for the purpose of providing information about Covered Services to Members; provided, however, such materials contain an appropriate copyright acknowledgment. Neither party shall reproduce any marketing, advertising, or promotional materials, including but not limited to, videos, brochures, posters, newsletters and any other copyrighted materials without the other party's prior written consent, unless expressly permitted otherwise under this Agreement.

SECTION 6
REGULATORY COMPLIANCE

6.1 Compliance with Laws, Regulations; Licensure. Vendor shall maintain and shall, as applicable, require all Participating Providers and health care professionals employed by or under contract with Vendor, to maintain all federal, state and local licenses, certifications, permits, regulatory approvals and accreditations, without material restriction, that are required to provide the services under this Agreement. Vendor and United shall comply (and, as applicable, Vendor shall require Participating Providers and health care professionals employed by or under contract with Vendor to comply) with all laws and regulations applicable to the services provided hereunder, including without limitation the regulatory provisions set forth in individual appendices attached to this Agreement and made a part hereof (the "Appendix(ces)"), which provisions are hereby incorporated into and made a part of this Agreement. United may add, delete or replace Appendices from time to time as necessary to comply with applicable law without amending this Agreement. Services rendered under this Agreement shall be subject only to those provisions in any Appendix that by law or regulation are applicable to such category of services. Vendor shall comply with the applicable terms and conditions of such Appendices.

Vendor shall notify United if a governmental authority notifies Vendor that it must be licensed as an insurer, health service plan, health maintenance organization, prepaid limited health services organization, or other type of licensed insurer to provide services. In such event, Vendor may cease providing the services that would subject Vendor to such licensure, unless Vendor and United can agree upon an amendment to this Agreement that would make such licensure unnecessary. Any such cessation of services shall be effective the earlier of the date required by the governmental authority or after at least sixty (60) days following prior written notice to United.

6.2 Protected Data. The parties acknowledge and agree that, in the course of performing hereunder, Vendor will receive on behalf of United personal data identifying individuals covered by United, protected health information, and other data protected by law. With respect to such data, Vendor and United shall comply with the Health Insurance Portability and Accountability Act of 1996, the Gramm-Leach -Bliley Act, and all other applicable confidentiality, privacy and data security laws and regulations.

6.3 Regulatory Approval and Filing. United shall be responsible for filing this Agreement with any governmental authorities as may be required by any applicable law or regulation. If the governmental authority requests changes to this Agreement, Vendor and United shall jointly discuss the response to the governmental authority. If any governmental authority requires a change to this Agreement that either Vendor or United deems to be material, either party may request re-negotiation of the affected provisions of this Agreement pursuant to Section 11.15.

6.4 Delegation of Activities; Oversight. To the extent applicable to any Covered Services, in compliance with the delegation and oversight obligations imposed on United, including by the applicable state or under its contracts with any state and/or federal regulatory agencies, United (a) shall conduct at least an annual audit of Vendor's performance of such delegated activities and (b) has the right (including if asked by a regulatory agency) to revoke any functions or activities delegated to Vendor under this Agreement, if in United's reasonable judgment, Vendor's performance under this Agreement does not comply with United's obligations. This right shall be in addition to United's termination rights under this Agreement.

6.5 Immunity. Vendor and United agree that activities delegated to Vendor by United may be considered professional and quality review procedures and that both Vendor and United may be immune pursuant to the Health Care Quality Improvement Act (42 U.S.C. 11101, et seq., as may be amended from time to time), or other state or federal law, from any civil liability arising from the delegated activities. Vendor agrees to maintain the confidentiality of any privileged information to the extent permitted by law and obtain United's prior written consent before disclosing privileged information to any third party, except as may otherwise required by law.

SECTION 7
TERM; TERMINATION

7.1 Term and Termination. This Agreement shall commence on the Effective Date and shall continue until terminated as follows:

(a) by mutual agreement of the parties;

(b) by either party upon at least 60 days prior written notice to the other party;

(c) by either party, upon at least 30 days prior written notice to the other party in the event of a material breach of this Agreement by the other party unless the material breach

has been cured or a reasonable corrective action plan has been developed and approved by the other party before the end of the notice period;

(d) by either party, immediately upon written notice to the other party, in the event of the other party's loss or suspension of material licensure, certification or other governmental authorization necessary to perform under this Agreement;

(e) immediately if required by a state or federal regulatory agency with jurisdiction over this Agreement.

In the event this Agreement is terminated, United shall provide notice thereof in accordance with all requirements of the insurance laws of the state in which United is domiciled.

Upon notice of termination of this Agreement given by one party to another, United shall pay all fees owed to Vendor pursuant to the payment terms under this Agreement and Vendor shall provide services until the effective date of the termination except as provided under Section 7.5 or otherwise required by law.

7.2 United Receivership. If United is placed in receivership pursuant to the relevant state receivership act:

(a) Vendor shall have no automatic right to terminate this Agreement;

(b) Vendor shall continue to maintain any systems, programs or other infrastructure notwithstanding such receivership and will make them available to the receiver for as long as Vendor continues to receive timely payment for services rendered;

(c) all of the rights of United under this Agreement shall extend to the receiver; and

(d) United's books and records shall immediately be made available to the receiver and shall be turned over to the receiver immediately upon the receiver's request.

7.3 Effect of Expiration or Termination. Upon the expiration or termination of this Agreement, Vendor will cooperate with United and/or United's designee to transition the care and management of Members undergoing treatment on the date of expiration or termination. Vendor, United and/or United's designee will work together to transition business, medical, and management records to United or United's designee in a commercially reasonable manner that reflects the rights and obligations of all parties, including Vendor's need for ongoing access to such records.

7.4 Notice to Members. Upon notice of termination of this Agreement, United and/or Payor shall have the right to notify, at their own expense, Members of such termination.

7.5 Continued Provision of Covered Services After Termination. Vendor agrees that in the event this Agreement is terminated, Vendor shall use commercially reasonable efforts to cause Participating Providers to continue to provide Covered Services to any Members undergoing treatment at the time of such termination until the earlier of:

(a) the current episode of treatment is completed, or as to any Members confined in inpatient facilities on the date of such termination, until such Members are discharged; or

(b) arrangements are completed for such Members to be transferred to another provider.

Participating Providers shall be reimbursed in accordance with their Provider Agreements for all such services rendered subsequent to the termination of this Agreement.

SECTION 8
INSURANCE

Unless otherwise agreed to by the parties in writing, Vendor shall procure and maintain the insurance or self-insurance programs in the minimum amounts set forth below. Any such self-insurance programs will include actuarially approved funding levels. Vendor will provide United evidence of such insurance upon request.

(a) Commercial general liability insurance coverage, including but not limited to errors and omissions, in the minimum amounts of one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate for the policy year.

(b) Professional liability insurance coverage in the minimum amounts of ten million dollars ($10,000,000) per occurrence and ten million dollars ($10,000,000) aggregate for the policy year.

(c) As applicable, worker's compensation insurance coverage for Vendor employees in an amount and form meeting all applicable legal requirements.

SECTION 9
INDEMNIFICATION

The parties shall each indemnify and hold the other harmless from and against any and all liabilities, including but not limited to, losses, penalties, fines, costs, damages, claims, causes of action, and expenses the other incurs, including reasonable attorneys' fees, to the extent caused by the indemnifying party's (a) material breach of this Agreement; or (b) willful misconduct or reckless or grossly negligent act or omission related to or in connection with performance under this Agreement.

SECTION 10
DISPUTE RESOLUTION

The parties shall attempt in good faith to resolve any disputes arising from this Agreement ("Disputes") in the normal course of business at the operational level.

Either party may elect to submit any Disputes that are not resolved by the parties to binding arbitration in accordance with the then current AAA Commercial Rules for disputes. The arbitrator(s) shall be bound by and shall follow the then current ABA/AAA Rules of Ethics for Arbitrators.

Any arbitration proceeding under this Agreement shall be conducted in the state of Minnesota. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law and applicable rules of evidence.

Unless otherwise agreed to by both parties, the parties expressly intend that any Dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the Dispute related to this Agreement.

The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

If any portion of this Section or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Section or Agreement. If any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

If a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved in accordance with this Section. If the Dispute is submitted to arbitration, the termination for breach will not take effect during the arbitration proceeding.

Neither party shall be liable to the other party for punitive, exemplary, consequential, indirect or special damages, in each case, except to the extent such damages result from an award of damages in a third party claim.

This Section is the parties sole recourse for any dispute resolution and the parties waive the right to seek relief from a court of competent jurisdiction, unless otherwise required by law.

SECTION 11
MISCELLANEOUS

11.1 Notices. All notices or other communication required under this Agreement shall be in writing (which may be electronic) and shall be deemed delivered when delivered personally or by e-mail, one day after delivery by commercial overnight delivery service, or if mailed, five days after the date of mailing.

11.2 Amendment. Except as may otherwise be set forth in this Agreement, this Agreement may be amended only by both parties agreeing to the amendment in writing and complying with any and all notice and/or approval requirements of the insurance laws of the state in which United is domiciled.

11.3 Assignment; Subcontracting; Successors and Permitted Assigns. Neither United nor Vendor may assign its rights or responsibilities under this Agreement without the prior written consent of the other party, with the exception that United may assign its rights and responsibilities under this Agreement to an affiliate. With respect to any assignment of this Agreement, the parties shall comply with any and all notice or approval requirements of the insurance laws of the state in which United is domiciled. To the extent permitted by law, Vendor shall have the right to subcontract all or a portion of its obligations to any third party or affiliate; provided, however, that (a) Vendor shall be responsible to United for those duties to the same extent that it would have been responsible without the use of an affiliate or subcontractor, and (b) Vendor will ensure that its affiliates and subcontractors comply with all the terms of this Agreement, including, without limitation, the obligation to perform the services hereunder in compliance with all applicable laws and regulations. To the extent required by any regulatory agency governing any Medicare or Medicaid or other

governmental benefit plans (or as may be set forth in an Appendix) or any accreditating agency, Vendor shall provide notice to United and/or obtain consent, prior to any subcontracting of any of its responsibilities under this Agreement. This Agreement shall be binding upon, inure to the benefit of, and be specifically enforceable by and against the parties and their respective successors and permitted assigns. Nothing expressed or referred to in this Agreement will be construed to give any person or entity other than the parties hereto any rights, remedies or claims under or with respect to this Agreement.

11.4 Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the state in which United is domiciled without regard to the conflicts of laws provisions thereof.

11.5 Entire Agreement; Counterparts. This Agreement, which incorporates all exhibits, attachments, addenda, and appendices, constitutes the entire agreement between the parties in regard to the subject matter contained in this Agreement. This Agreement replaces any prior written or oral communications or agreements between the parties relating to the subject matter contained in this Agreement. In the event of a conflict between the provisions of the main body of this Agreement and an Appendix or an exhibit, the terms of the applicable Appendix or exhibit will control. The headings and titles within this Agreement are for convenience only and are not part of the Agreement. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which taken together shall constitute one and the same instrument..

11.6 Marketing; Advertising; Use of Names and Trademarks. During the term of this Agreement, the parties shall have the right to designate and make public reference to the other party by name in an accurate and factual manner, as the company providing, managing and/or arranging for the provision of services. Vendor and United shall not otherwise use the other party's name, trademarks, or service marks without prior written approval. The parties mutually agree to provide, at a minimum, forty-eight (48) hours advance notice and opportunity to comment on all press releases, advertisements or other media statements and communications regarding this Agreement, the services or the business relationship between the parties. Vendor shall obtain United's consent prior to any publication or use of such materials or communications. Notwithstanding the foregoing, if Vendor wishes to make a press release, advertisement or other media statement or communication that requires prior approval of a state or federal regulator, United shall be responsible for seeking such approval in a timely manner and Vendor agrees it will not proceed with the statement or communication until the required approval is obtained. Nothing herein shall be construed to create a right or license to make copies of any copyrighted materials.

11.7 Excluded Individuals. Neither Vendor nor United shall employ or contract any individual or entity (a) excluded from participation in Medicare or a state health care program or (b) any entity that employs or contracts with such an individual or entity to provide services under this Agreement.

11.8 Non-waiver. The failure of either party to insist upon the strict observance or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy. Nothing in this Agreement shall be considered waived by either party unless the party claiming the waiver receives the waiver in writing signed by an authorized signatory. A waiver of one right, remedy or strict observation or performance of a provision does not constitute a waiver of any other.

11.9 Relationship Between Parties. The relationship between the parties to this Agreement is solely that of independent contractors. Nothing in this Agreement or otherwise shall be construed or

deemed to create any other relationship, including one of employment, partnership, agency, joint venture, association or any other form of separate legal entity or organization.

11.10 Survival of Terms. Any provisions of this Agreement including any attachments hereto, that, by their nature, extend beyond the expiration or termination of this Agreement shall survive the termination of this Agreement and shall remain in effect until all such obligations are satisfied.

11.11 No Third Party Beneficiaries. This Agreement is intended solely for the benefit of the parties hereto and no third parties shall have any rights hereunder or interest herein except as explicitly provided herein.

11.12 Force Majeure. The obligations of a party under this Agreement will be suspended for the duration of any force majeure applicable to that party. The term "force majeure" means any cause not reasonably within the control of the party claiming suspension, including, without limitation, an act of God; war; riot; invasion; acts of a foreign enemy; terrorist action; weather-related disaster and governmental action. A party claiming suspension under this Section shall use its best efforts to resume performance as soon as possible.

11.13 Arm's Length Negotiations. The parties acknowledge that the terms of this Agreement are fair and reasonable, were negotiated at arm's length, and that the parties were given ample opportunity to review and consider this Agreement prior to execution.

11.14 Offshoring. To the extent mandated by law, contract or the applicable regulatory agency, United will notify Vendor of any requirements or restrictions for Vendor performing any of the services outside of the United States. Vendor shall comply with such requirements or restrictions.

11.15 Substantial Change. The parties may renegotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a Substantial Change which presents a fundamental departure from the risk, services, administration, costs or expenses or other assumptions or intent of the parties in entering into either this Agreement, including without limitation:

(a) A significant reduction in the number, or change in the composition of, Member enrollment;

(b) A material change in utilization or trends;

(c) A material modification of an existing Benefit Plan;

(d) Development of a new Benefit Plan;

(e) Expansion of a Service Area to a geographic area of the country not originally contemplated under this Agreement; or

(f) A significant change in any law, rule, regulation or interpretation thereof that would have a material and adverse effect on the ability of a party to receive the benefits it reasonably expects to obtain under this Agreement or renders it illegal for a party to continue to perform under this Agreement in a manner consistent with the parties' intent.

The affected party must promptly notify the other party of the Substantial Change and its desire to renegotiate this Agreement. This section does not affect either parties' right to terminate this Agreement in accordance with Section 7.1.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

United Behavioral Health	UnitedHealthcare of Louisiana, Inc.
Signature: Leslie J. Davis (Feb 28, 2012)	**Signature:** Bridget Galatas (Feb 27, 2012)
Email: leslie.davis@optum.com	**Email:** bridget_l_galatas@uhc.com
Title: CFO	**Title:** Director of Finance Chief Financial Officer Bridget L. Galatas

Internal Control No.: BS-35579
IIPAS No.: 6088-A-000

EXHIBIT LIST

X	Exhibit A:	Compensation for Services Addendum (Plans; Service Areas)
X	Exhibit B:	Services Addendum
N/A	Exhibit C:	Medicare Advantage Regulatory Requirements Appendix
N/A	Exhibit D:	HMO or Insurance Specific Requirements Appendix
N/A	Exhibit E:	Medicaid State Regulatory Requirements Appendix
X	Exhibit F:	Delegation of Credentialing Addendum

Any exhibits not checked or designated as N/A have been intentionally omitted.

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the tables below.

Segment	Line of Business	Service	Service Type	Service Area	Rate	Rate Type	ASO or Full Service Benefit Plans
E&I	Commercial	Employee Assistance Program (EAP)	Mental Health	N/A	[redacted]	PMPM	ASO
E&I	Commercial	HMO In Network	Mental Health	Louisiana	[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Mental Health	Louisiana	[redacted]	PMPM	ASO

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

United shall pay all Monthly Fees on or before the fifteenth (15th) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

EXHIBIT B
SERVICES ADDENDUM

Behavioral Health

Vendor shall provide the services described in this Addendum.

To the extent required by a regulatory or accreditating agency,

(a) the parties shall document to the level of specificity required by applicable government authorities and/or United's accreditation agencies the activities relating to the services that have been delegated under this Exhibit to Vendor in accordance with the timeframes required;

(b) before activities are delegated under this Agreement, United will or has conducted a pre-assessment audit of Vendor to assess Vendor's ability to fulfill the terms of this Agreement for any delegated activities; and

(c) upon request by United, Vendor shall cooperate and participate, either telephonically or personally, in accreditation and/or state or federal regulatory audits, including interview sessions, related to the delegated activities provided under this Agreement. This section (c) shall survive termination of this Agreement, Exhibit and the delegated activities.

SECTION 1
NETWORK MANAGEMENT

1.1 Network Development. Vendor shall arrange for Participating Providers to provide Covered Services to Members. United may recommend to Vendor that certain providers become Participating Providers. In no case shall this provision be construed to obligate Vendor to contract with or make use of any particular health care facility or professional. Vendor retains full and complete rights to terminate a Participating Provider's Provider Agreement with Vendor. Vendor makes no representations or guarantees regarding the continued availability of any Participating Provider. Vendor shall provide United with electronic access in a mutually agreeable format to a listing of Participating Providers that Vendor will update monthly. In the event of termination of a Participating Provider, Vendor shall assist Members in transitioning to a new Participating Provider within a reasonable time or such timeframe as required by applicable state and/or federal law. Any material changes to the composition of the Provider network may be subject to prior written notification to the applicable state and/or federal regulatory authorities.

1.2 Participating Provider Insurance. Vendor shall require Participating Providers to procure and maintain applicable malpractice and/or professional liability insurance equal to the prevailing community standard unless (a) applicable state law or regulation requires otherwise, or (b) United provides notice in advance of implementation of other insurance requirements.

1.3 Geographic Access. Upon United's written request, Vendor shall provide United with a current listing of Participating Providers. Vendor's Participating Provider network will be sufficient to ensure that all Members within United Service Area have reasonable access to Covered Services and in accordance with applicable state and federal law or state contract availability and access requirements. If United reasonably determines that there are not sufficient Participating Providers to provide Covered Services to Members:

- United shall notify Vendor of the alleged deficiency;

- United and Vendor shall meet to discuss the alleged deficiency; and

- If appropriate, develop a mutually satisfactory plan of correction within thirty (30) days of such notice.

United shall have the ability to impose unilaterally a corrective plan of action if the parties cannot develop such a plan in a timely and mutually satisfactory manner. United shall notify Vendor in writing at least ninety (90) days prior to any modification of United's Service Area. Vendor shall use best efforts to arrange for Participating Providers in such expanded Service Area within ninety (90) days of receiving such notice, at which time the definition of Service Area in this Agreement shall include such expansion without further compliance with Section 11.2 of the Agreement.

1.4 Vendor's Provider Agreements and Manuals. Vendor's network participation requirements shall be set forth in its Provider Agreement, operations manual, and/or credentialing and recredentialing plan, all of which shall be made available to United upon written request. Vendor must have a written agreement in effect with each Participating Provider and shall ensure that its Provider Agreements and related manuals comply with all applicable laws, regulations, government programs and accrediting agency standards. Vendor understands and agrees that Vendor and Participating Providers may be subject to United's administrative guide and/or provider manual for the provision of Covered Services for certain state or federal government program Benefit Plans. The Provider Agreements will require Participating Providers to comply with all applicable obligations in this Agreement and ensure that Members have access to Participating Providers for the programs and/or products set forth in Exhibit A. Vendor and United shall work together in good faith to address any concerns United has regarding the content of such agreements and manuals.

Vendor shall cooperate with and provide to United copies of the Provider Agreements and manuals that United is required to file or submit for regulatory or accreditation purposes and agrees to work with the regulators or administrators to address any concerns regarding the content of such agreements or manuals.

If Vendor intends to make any substantial changes to its Provider Agreements or manuals that would materially affect this Agreement or require filing or submission to United's regulators or administrators, Vendor shall notify United of such proposed changes in advance of their effective dates. Vendor and United shall work together in good faith to resolve any concerns United may have about the proposed changes and to complete any filing or submission United is required to make.

1.5 Right to Approve, Suspend, or Terminate Participating Providers. United retains the absolute right to approve, suspend or terminate a Participating Provider for participation in any or all of its Benefit Plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate, until such provider is credentialed. United shall promptly inform Vendor and the affected Participating Provider of any denial, restriction or revocation of a Participating Provider's participation status in any or all of United's Benefit Plans. In no case shall this Section be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

1.6 Discontinuing Use of a Participating Provider. Vendor shall discontinue referrals to or otherwise using a Participating Provider for Covered Services upon the occurrence of any of the following:

(a) immediately upon expiration of the cure period for a material breach; provided, however, that Vendor shall have sixty (60) days from the date it receives written notice from United identifying the Participating Provider's conduct that violates a material term of this Agreement or Vendor's agreement with the Participating Provider to cure such defect;

(b) immediately upon Vendor's receipt of written notice that the Participating Provider's license or certification has been revoked, suspended or otherwise limited;

(c) immediately upon Vendor's receipt of written notice that the Participating Provider's liability insurance has been revoked;

(d) immediately upon Vendor's receipt of written notice that the Participating Provider has been sanctioned by a state or CMS; or

(e) immediately upon termination of the Participating Provider's agreement with Vendor.

Vendor will notify United of Vendor's discontinued use of a Participating Provider to permit United to comply with its obligations under federal or state law or state contract to notify the applicable state and its Members of changes to provider networks. Vendor shall provide this notice at least thirty (30) days prior to its discontinuation of a Participating Provider. If thirty (30) days advance notice is not possible, the notice must be as soon as possible. The parties agree and acknowledge that under no circumstance shall services to Members be disrupted. Vendor agrees to abide by all applicable laws and regulations to provider appeals of termination.

SECTION 2
CREDENTIALING AND RECREDENTIALING

2.1 Participating Provider Credentialing. Vendor shall establish and maintain a credentialing and re-credentialing process to which all professional Participating Providers shall be subject in accordance with the Delegation of Credentialing Addendum, attached to this Agreement as Exhibit F. Upon United's written request, Vendor shall provide United with a copy of Vendor's credentialing process. Vendor's credentialing process shall comply with Exhibit F of this Agreement and the applicable requirements of the National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations or another generally recognized accrediting agency ("Accrediting Agency") and for Medicare, Medicaid, and any other government business, any additional requirements under state or federal law. The services performed by Vendor under the Delegation of Credentialing Addendum shall be pursuant to the monitoring, oversight and approval of United. With reasonable prior written notice and during normal business hours, United may conduct comprehensive onsite evaluation of Vendor's credentialing procedures. Vendor shall immediately provide documentation to United related to any issue concerning quality of care or related to any investigation or inquiries by regulatory agencies of any Participating Provider.

SECTION 3
UTILIZATION MANAGEMENT AND/OR COMPLEX CASE MANAGEMENT

3.1 Utilization Management and/or Complex Case Management. Vendor shall be delegated for utilization management and/or complex case management services as designated by United. Vendor shall establish and maintain a utilization management program and/or complex case management program to which all professional Participating Providers will be subject. Upon United's written request, Vendor shall provide United with a copy of Vendor's utilization management and/or

complex case management process. Vendor's process shall comply with the applicable requirements of the National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations or another generally recognized accrediting agency ("Accrediting Agency") and for Medicare, Medicaid, and any other government business, any additional requirements under state or federal law. The delegated services performed by Vendor shall be pursuant to the monitoring, oversight and approval of United. With reasonable prior written notice and during normal business hours, United may conduct comprehensive onsite evaluation of Vendor's utilization management and/or complex case management procedures.

SECTION 4
CLAIMS ADMINISTRATION

4.1 Claims Administration. Vendor shall perform certain claims administration services for claims associated with Covered Services provided to Members as described in this Section. Vendor shall arrange for Participating Providers to submit claims for Covered Services to Vendor. Claims shall be paid in accordance with the terms and conditions of the Benefit Plans, Vendor's agreements with Participating Providers, this Addendum, this Agreement, and any applicable state or federal requirements.

4.2 Benefit Administration. Vendor shall make initial determinations whether services and/or supplies requested by or on behalf of a Member or for which a Member has requested reimbursement are Covered Services.

If Vendor determines that the requested services and/or supplies are not Covered Services, Vendor shall notify the Member about the lack of coverage and the Member's rights under the Benefit Plan to appeal a denial of coverage.

4.3 Member and Provider Appeal and Grievance Process.

(a) In the event of disputes with a Member or Provider regarding coverage of Covered Services, Vendor shall refer the Member or Provider to the appropriate appeal and grievance processes under the Member's Benefit Plan. Vendor shall cooperate with United with respect to any such appeal or grievance processes. The result of the Member appeal and grievance process shall be binding on Vendor, unless Vendor notifies United that Vendor disagrees with such result within fifteen (15) business days after Vendor receives notice of the result. In such case, United or Payor may authorize coverage and pay for the provision of the services and/or supplies in dispute, and the parties shall proceed with the dispute resolution process described in Section 4.4 of this Addendum.

(b) In the event of a dispute with a Provider regarding payment, Providers will utilize Vendor's policies and procedures for the appropriate appeal and grievance process. Vendor shall ensure that its provider dispute process is in compliance with all applicable state and federal requirements for both participating and non-participating providers. Vendor will notify United of Provider disputes and provide all necessary data to United regarding the dispute, and will maintain such dispute records as required by law. United shall cooperate with Vendor with respect to any such appeal or grievance process and unless otherwise required by state or federal requirements be bound by Vendor's resolution of the dispute.

4.4 Coverage Disputes between Vendor and United or a Payor Regarding Members. In the event: (a) of a dispute between Vendor and United or a Payor regarding whether particular services and/or

supplies for a Member are Covered Services for which Vendor has financial responsibility; or (b) if United or a Payor enters into a settlement agreement with a Member as a result of actual or threatened grievance, arbitration or litigation, and United or Payor and Vendor do not agree on financial liability for such services (collectively, a "Coverage Dispute"), the parties shall comply with the following Coverage Dispute resolution procedure:

(i) The Coverage Dispute shall be submitted to United's or the Payor's and Vendor's medical directors, or equivalent, for review.

(ii) The medical directors shall issue their determination within seven (7) business days after submission and receipt of appropriate and necessary information.

(iii) If there continues to be a Coverage Dispute after the medical directors' review, the parties shall submit the Coverage Dispute to the appropriate senior executive at each organization, who shall issue their determination within seven (7) business days after submission.

(iv) If there continues to be a Coverage Dispute, the affected parties may initiate dispute resolution pursuant to Section 10 of this Agreement.

4.5 Effect of Expiration or Termination. When this Agreement or this Addendum expires or is terminated, the parties agree as follows:

Vendor is administratively responsible (and is also financially responsible for the Full Service Benefit Plans) for any claims for Covered Services provided prior to the expiration or termination date, even if the claim for such Covered Services is not received until after the expiration or termination date. The applicable terms of this Addendum, including Sections 4.1 to 4.4, apply to such claims.

Vendor is also administratively responsible (and is also financially responsible for the Full Service Benefit Plans) for any claims for Covered Services provided after the expiration or termination date if the claim is related to completing Covered Services that started prior to the expiration or termination date. Completing such Covered Services is included in the payments Vendor received prior to the expiration or termination date. The applicable terms of this Addendum, including Sections 4.1 to 4.4, apply to such claims.

Vendor is not financially or administratively responsible for any other claims for Members that are related to Covered Services provided after the expiration or termination date. Vendor shall promptly forward any claims it receives for post-expiration or post-termination date Covered Services for Members that are not Vendor's responsibility to United or United's designee in a manner consistent with any agreement reached.

SECTION 5
OTHER SERVICES

5.1 General Services. In addition to the services described herein, Vendor shall provide the following:

(a) Vendor will provide United with the reports identified below regarding Covered Services. Vendor shall provide such reports to United no later than thirty (30) business days after the end of each month or calendar quarter, as appropriate or as required by statutes, laws or regulations.

(i) Vendor shall provide United, in a format specified by United, a monthly file of those Participating Providers either terminated from or added to Vendor's network to ensure that United can update its system appropriately or as required by statutes, laws or regulations.

(ii) Vendor shall provide standard monthly and quarterly cumulative reports. Vendor agrees to cooperate with United in preparing any encounter or other reports, including but not limited, denial rate reports; aged claims reports; claims audit reports; coordination of benefits collection from third parties reports; and any other reports that may be required by any applicable state contract, state or federal regulatory agencies

(iii) Upon agreement of the parties and for an additional fee, Vendor shall provide, within a time period mutually agreed to by the parties, specialized reporting of data regarding Covered Services provided or authorized by Vendor.

(iv) Vendor and United agree that United may receive one ad hoc report at no additional cost. Additional requests, description of work, terms, schedules and rates shall be detailed and mutually agreed to by United and Vendor prior to commencement of the work.

(b) Vendor shall make commercially reasonable efforts to provide Participating Provider contact information required for basic service calls from Members. Vendor shall provide a monthly report to United of such service calls.

(c) Vendor shall cooperate with United with respect to surveys of a sample of Members who have accessed Covered Services pursuant to this Agreement and/or Participating Providers to assess satisfaction with Vendor. If areas of dissatisfaction are identified as a result of such surveys, Vendor will develop commercially reasonable corrective strategies for mutually identified areas of concern.

5.2 Quality Management. United and Vendor shall establish and maintain their own quality management programs and such other assessment and improvement programs determined to be appropriate. Vendor shall cooperate with, and shall use reasonable efforts to ensure Participating Providers cooperate with, any such reasonable and similar programs established or required by United, a Payor, or any applicable state or federal regulatory agency.

SECTION 6
MISCELLANEOUS

Vendor acknowledges that in receiving, storing, processing or otherwise dealing with information about Members, it may be fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and agrees that, if so, it shall resist, in judicial proceedings, any effort to obtain access to information pertaining to Members that is expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

EXHIBIT C

INTENTIONALLY OMITTED.

EXHIBIT D

REGULATORY REQUIREMENTS APPENDIX

INTENTIONALLY OMITTED.

EXHIBIT E

REGULATORY REQUIREMENTS APPENDIX

INTENTIONALLY OMITTED.

EXHIBIT F

DELEGATED CREDENTIALING ADDENDUM

THIS DELEGATED CREDENTIALING ADDENDUM (this "Addendum"), supplements and is made a part of this Agreement.

SECTION 1
DEFNITIONS

All capitalized terms not otherwise defined herein shall have the meanings given to such terms in this Agreement.

1.1 **Complaint:** Any written or oral communication made by a Member or his or her authorized representative that expresses dissatisfaction about United, a Participating Practitioner or Component, or United's products, benefits, coverage, services or operations.

1.2 **Component:** A hospital, skilled nursing facility, outpatient surgical center, free-standing surgical center, such as stand-alone abortion clinics and multispecialty outpatient surgical centers, or a similar facility (or as otherwise defined by the Credentialing Authorities), that is required by United and the Credentialing Authorities to be Credentialed to participate in United Network.

1.3 **Credential(ed), Credentialing or Recredentialing:** The process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Practitioners or Components, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.

1.4 **Credentialing Authorities:** The National Committee for Quality Assurance ("NCQA") or other accrediting body as applicable to United, the Center for Medicare and Medicaid Services ("CMS"), as applicable, and other state and federal regulatory authorities, to the extent such authorities dictate credentialing requirements.

1.5 **Credentialing Plan:** United's policy for Credentialing and Recredentialing of Practitioners and Components. To the extent the Credentialing Plan varies from any legal requirement, the law will control. The Credentialing Plan shall also include any state or federal regulatory requirements attached to the Credentialing Plan.

1.6 **Participating Component:** A Component that is included in United Network, directly or through another entity, pursuant to a Participation Agreement.

1.7 **Participating Practitioner:** A Practitioner that is included in United Network, directly or through another entity, pursuant to a Participation Agreement.

1.8 **Participation Agreement:** For purposes of this Addendum, an agreement that sets forth the terms and conditions under which a Practitioner or a Component, either directly or through another entity, participates in Vendor's Network.

1.9 **Practitioner:** A licensed or otherwise appropriately qualified health care professional or entity who is qualified and, when applicable, duly licensed and/or certified by the state in which he, she or it is located to furnish Covered Services when acting within the scope of his, her or its license or certification.

1.10 **Quality of Care:** The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include the following: Member perspective issues, safety of the health care environment, accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of care.

1.11 **United Network:** The network of Practitioners and/or Components established by United to provide or arrange for the provision of health care services to Members.

1.12 **Vendor Network:** The network of Practitioners and/or Components established by Vendor to provide or arrange for the provision of health care services.

SECTION 2
VENDOR RESPONSIBILITIES

2.1 **Policies and Procedures.** Vendor may utilize its own policies and procedures for the performance of delegated activities set forth in this Addendum, subject to the terms and provisions hereof, and provided that such policies and procedures remain in compliance with the reasonable requirements of United, and applicable state and federal law and accreditation standards. All such policies and procedures shall be forwarded to United, on an annual basis or upon request, for ongoing review and approval.

2.2 **Compliance with Standards and Applicable Law.** Vendor shall at all times meet the applicable standards for Credentialing and Recredentialing, as required by Credentialing Authorities and as set forth in the most current Credentialing Plan. United shall provide Vendor a copy of the Credentialing Plan through regular mail or electronically. United may unilaterally change its Credentialing Plan by providing thirty (30) days prior written notice to Vendor of the changes and their effective dates; provided, however, if required by Credentialing Authorities, United may unilaterally change the Credentialing Plan immediately without prior written notice to Vendor of the changes and their effective dates. Any notice provided to Vendor under this Section may be in electronic format. Vendor shall also comply with all applicable laws related to the performance of delegated activities.

2.3 **Delegated Activities.** Vendor shall perform such delegated activities as United deems appropriate, including the Credentialing of Practitioners and Components in accordance with the Credentialing Plan, as may be amended from time to time, and the requirements set forth by the Credentialing Authorities. Vendor understands and agrees that Practitioners and Components may not provide health care services to a Member unless and until such Practitioners and Components are properly Credentialed and have executed or are otherwise subject to a Participation Agreement. Vendor will not communicate anything to the contrary to a Practitioner or Component.

2.4 **Credentialing of Practitioners.** The Credentialing of Practitioners by Vendor shall include, but is not limited to:

(a) establishing and maintaining credentialing standards, policies and procedures;

(b) receiving the provider's application, reapplication and attestation, including documentation required under state and federal rules, regulations and any applicable contract between United and a state;

(c) conducting office site visits as required by applicable law and/or state contract and medical record keeping assessments;

(d) recredentialing Practitioner every thirty-six (36) months, unless otherwise required by applicable law, but confirming the Practitioner has not been denied Credentialing from United in the previous twenty-four (24) months;

(e) confirming the Practitioner has active hospital staff privileges at a participating hospital, if applicable to Practitioner's practice;

(f) confirming the Practitioner is Medicaid-enrolled and agrees to comply with all pertinent Medicaid regulations as applicable for participation in Medicaid programs

(g) making decisions on Credentialing; and

(h) the ongoing monitoring and evaluation of Complaints, sanctions on licenses, Medicare/Medicaid Complaints, and Quality of Care issues.

(i) primary source verification, where applicable, of the Practitioner's education, including successful completion of a residency program, board certifications, current licensure or certification and any sanctions or limitations thereon;

(j) registration with the Drug Enforcement Agency;

(k) possession of a State Controlled Dangerous Substance Certificate, as applicable;

(l) current, active malpractice insurance or state-approved alternative;

(m) malpractice history;

(n) work history; and

(o) verification that the Practitioner has not opted out of participation with Medicare, is not ineligible, excluded or debarred and does not have any restrictions, sanctions, censures or other disciplinary action (other than action regarding incomplete medical records) against him/her by any state or county medical association, medical staff, hospital, state or federal programs, including but not limited to, Medicare or Medicaid.

2.5 **Credentialing of Components.** If the Vendor Network includes Components, Vendor shall Credential the Components on behalf of United. The Credentialing of Components shall include, but is not limited to:

(a) establishing and maintaining Credentialing standards, policies and procedures;

(b) verification of current licensure or certification and any sanctions or limitations thereon;

(c) verification that the Component is not ineligible, excluded or debarred and does not have any restrictions, sanctions or other disciplinary action against it by any state or federal programs;

(d) verification of current, active malpractice insurance or state-approved alternative;

(e) appropriate accreditation, certification or satisfactory alternative or a passing score on Component site visits;

(f) making decisions on Credentialing; and

(g) the ongoing monitoring and evaluation of Complaints, sanctions on licenses, Medicare/Medicaid Complaints, and Quality of Care issues.

2.6 **Right of Appeal.** If Vendor makes a decision to suspend or terminate a Participating Practitioner or Participating Component from Vendor's network, Vendor shall, in accordance with Vendor's and United's credentialing policies and procedures, offer such Participating Practitioner or Component the right to appeal or request a fair hearing. Vendor shall conduct the appeals process and report the action, as required by the Credentialing Authorities.

2.7 **Audit Participation.** Vendor shall fully cooperate and participate, either telephonically or personally, in audits conducted by Credentialing Authorities, including interview sessions, upon fourteen (14) calendar days notice from United, unless the Credentialing Authorities require a shorter timeframe. This Section shall survive any termination of this Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.8 **Records.** Unless applicable statutes or regulations require a longer time period, Vendor shall retain all information and records related to this Addendum according to United's record retention policies, or for at least ten (10) years, or as otherwise required by law. United, Credentialing Authorities and any federal, state or local governmental official or their authorized representatives who audit United shall have access to all records or copies which are pertinent to and involve transactions related to this Addendum if such access is necessary to comply with United's policies, applicable accreditation standards, statutes, or regulations. Photocopying and mailing of records pursuant to this section shall be at no charge to United. United and Vendor shall maintain the privacy of all information regarding Members, Covered Services Participating Practitioners and Participating Components in accordance with applicable statutes and regulations. This Section shall survive any termination of this Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.9 **Improvement Action Plan.** In the event that, during an audit or any other time during the term of this Addendum, United discovers any deficiency(ies) in Vendor's delegated activities, Vendor shall develop an Improvement Action Plan for the specific activity that United determines to be deficient. The Improvement Action Plan shall include specifics of and timelines for correcting any deficiencies or issues contained in the audit report to Vendor. Vendor shall implement the Improvement Action Plan within the specified timeframes. In the event the Improvement Action Plan is not developed and/or implemented within such timeframes, United may revoke all or certain delegated activities pursuant to Section 3.3 of this Addendum. If deficiencies are identified, United retains the right to increase its monitoring, evaluations, and audits of Vendor until the deficiencies are corrected.

2.10 **Documentation and Information.** Vendor shall provide to United the following documentation and information according to the time periods listed below:

(a) **Inquiries and Investigations.** Within ten (10) business days of Vendor's knowledge of actions taken as a result of any inquires or investigation by regulatory agencies, or Quality of Care issues investigated by Vendor, that result in the limitation,

restriction, suspension or termination of a Participating Practitioner's or Component's ability to provide services to Members, Vendor shall provide United with documentation related to such inquires or investigations. Vendor is not required to provide United with information that is peer review protected or documents and deliberation considered confidential or privileged by HCQIA (Health Care Quality Improvement Act-1986) or according to state peer review laws.

(b) **United Network Updates.** Vendor shall provide United with information about Participating Practitioners or Components who have changes to their demographic information, who have been Credentialed or Recredentialed, or who have been terminated, suspended, or restricted from participating in Vendor's network as changes occur, but no later than five business days from the time such changes occur. Such information shall be in an electronic format mutually agreed upon by the parties and shall include all information United needs to meet its database requirements. A sample of the format, content and where to submit this information shall be made available to Vendor on an electronic basis. United may unilaterally change its Credentialing and Recredentialing database requirements by providing thirty (30) days advance notice, in an electronic format, to Vendor of the changes and their effective date.

(c) **Improvement Action Plan Items.** Every six (6) months after the Effective Date of this Agreement, Vendor shall provide United with any outstanding Improvement Action Plan items.

(d) **List of Participating Practitioners and Components.** Upon United's request, which will be at least semi-annually and annually, Vendor shall provide United with a complete list of Participating Practitioners and Components currently active in United Network and Credentialed by Vendor.

SECTION 3
COMPANY'S RESPONSIBILITIES

3.1 **Pre-Delegation Assessment.** The parties acknowledge that United has completed a pre-assessment audit of Vendor to assess its ability to fulfill the terms of this Addendum.

3.2 **United Delegation, Oversight, Monitoring and Audit.** United shall perform oversight and monitoring of Vendor's performance under this Addendum, including but not limited to, review of the documentation and information related to delegated activities, as set forth in Section 2.10 of this Addendum. At any time, but at least annually, United will audit records and documents related to the activities performed under this Addendum, including but not limited to Vendor's Credentialing and Recredentialing files. United, in its sole discretion, will conduct desk-top review of Vendor's written policies and procedures and will perform file review audits at the site of Vendor. United will provide written notice of annual audits at least thirty (30) calendar days prior to the audit. United shall provide a report of its audit findings to Vendor within thirty (30) calendar days of the audit's conclusion. For all additional audits, United shall provide at least fourteen (14) calendar days prior written notice, unless state or federal regulators or other Credentialing Authorities require a shorter timeframe. The audit notes shall include a list of the records to be reviewed.

3.3 **Revocation of Delegation.** United may revoke the delegation of some or all of the activities which Vendor is obligated to perform under this Addendum in the event Vendor fails to meet the requirements of United, applicable law, regulations, or accreditation standards in the performance of the delegated activity(ies).

3.4 **Right to Approve, Suspend, or Terminate Practitioners.** United retains the absolute right to approve or reject a Practitioner or Component for participation in United Network or in any or all of its Benefit Plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate, until such Practitioner or Component is Credentialed. United shall promptly inform Vendor and the affected Practitioner or Component of any denial, restriction or revocation of the provider's participation status in United Network or a Benefit Plan, as determined by United. United also retains the absolute right to terminate or suspend any Participating Practitioners or Components from participation in United Network or in any or all of its Benefit Plans. In no case shall this Section be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

SECTION 4
TERM

4.1 **Term.** This Addendum shall run co-terminously with this Agreement, except that United may revoke any or all delegated activities at any time pursuant to Section 3.3.

4.2 **Records Upon Termination.** Upon the effective date of termination of this Agreement or revocation of all Delegated Activities pursuant to Section 3.3, Vendor shall provide United with a list of all Participating Practitioners and Participating Components that Vendor has Credentialed on United's behalf. Also, upon request by United, and if agreed to by Vendor, Vendor shall provide United with copies of Vendor's Credentialing and Recredentialing files that pertain to this Addendum. Such files shall be provided to United no more than thirty (30) days after the effective date of termination of this Agreement or revocation of all Delegated Activities pursuant to Section 3.3 of this Addendum.

SECTION 5
SUB-DELEGATION

Under certain circumstances, United may allow Vendor to sub-delegate all or a part of its delegated activities under this Addendum to another entity. Prior to any such sub-delegation arrangement, Vendor must:

(a) Warrant that the sub-delegation agreement between Vendor and the sub-delegated organization meets the requirements of Credentialing Authorities and all terms and provisions of this Addendum;

(b) Agree to oversee and perform audits of those activities it has sub-delegated to another entity in accordance with the requirements of Credentialing Authorities and this Addendum;

(c) Provide all reports to United that are required under this Addendum;

(d) Not enter into the sub-delegation agreement until it receives United's prior written approval; and

(e) Assure that Vendor's ownership interest in the sub-delegate is less than one-hundred percent (100%).

Amendment No. 1 to Agreement
Between United Behavioral Health and UnitedHealthcare of Louisiana, Inc.

This Amendment No. 1, ("Amendment") dated March 1, 2013, (the "Amendment Effective Date") is entered into by and between United Behavioral Health, including its affiliates, with its principal place of business at 6300 Olson Memorial Highway, Golden Valley, MN 55427 ("Vendor"); and UnitedHealthcare of Louisiana, Inc. with its principal place of business at 3838 North Causeway Boulevard Suite 2100, Metairie LA 70002 ("United").

Whereas, Vendor and Client are parties to the Agreement dated March 1, 2012 (the "Agreement") for the provision of certain services by Vendor to United; and

Whereas, the parties desire to amend certain terms and conditions of the Agreement in accordance with this Amendment and agree to new terms and conditions as set forth herein; and

Now, Therefore, the parties mutually agree as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. The rate chart in Section 1 of Exhibit A of the Agreement shall be deleted and replaced with the following rate chart:

Segment	Line of Business	Service	Service Type	Service Area	Rate	Rate Type	ASO or Full Service Benefit Plans
E&I	Commercial	Employee Assistance Program (EAP)	Mental Health	N/A	[redacted]	PMPM	Full Service
E&I	Commercial	HMO In Network	Mental Health	Louisiana	[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Mental Health	Louisiana	[redacted]	PMPM	ASO

3. This Amendment and the Agreement constitutes the entire agreement and understanding of the parties hereto and supersede all prior agreements, consents, and understandings relating to the subject matter hereof whether oral or in writing. The parties agree that there are no other oral or other agreements between the parties that have not been incorporated into this Amendment and the Agreement.

4. Each of the persons signing this Amendment represents and warrants that he/she is a duly authorized officer, director or agent of the party on whose behalf the person is signing, and further represents and warrants that the person signing has the power and authority to bind the party, and that the party has the legal power to enter into this Amendment.

[Signatures on following page.]

United Behavioral Health
6300 Olson Memorial Highway
Golden Valley, MN 55427

Signature: Leslie J. Davis
Leslie J. Davis (Apr 30, 2013)

Email: leslie.davis@optum.com

Print Title: CFO

IIPAS No: 6088-B
Internal Control No.: 44684

UnitedHealthcare of Louisiana, Inc.
3838 North Causeway Boulevard Suite 2100
Metairie, LA 70002

Signature: Bridget L Galatas
Bridget L Galatas (Apr 29, 2013)

Email: bridget_l_galatas@uhc.com

Print Title: Director of Finance

CONFIDENTIAL

Amendment No. 2 to Agreement
Between United Behavioral Health and UnitedHealthcare of Louisiana, Inc.

This Amendment No. 2, ("Amendment") dated February 1, 2014, is entered into by and between United Behavioral Health, including its affiliates ("Vendor"); and UnitedHealthcare of Louisiana, Inc. ("United").

Whereas, Vendor and United are parties to the Agreement dated March 1, 2012 (the "Agreement") for the provision of certain services by Vendor to United; and

Whereas, the parties desire to amend certain terms and conditions of the Agreement in accordance with this Amendment and agree to new terms and conditions as set forth herein; and

Now, Therefore, the parties mutually agree as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. The rate chart in Exhibit A Compensation for Services Addendum, Section 1 Compensation for Vendor Services, of the Agreement shall be deleted and replaced with the following rate chart:

Segment	Line of Business	Service	Service Type	Service Area	Rate	Rate Type	ASO or Full Service Benefit Plans
E&I	Commercial	Employee Assistance Program (EAP)	Mental Health	N/A	$ [redacted]	PMPM	Full Service
E&I	Commercial	HMO In Network	Mental Health	LA	$ [redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Mental Health	LA	$ [redacted]	PMPM	ASO

3. This Amendment and the Agreement constitutes the entire agreement and understanding of the parties hereto and supersede all prior agreements, consents, and understandings relating to the subject matter hereof whether oral or in writing. The parties agree that there are no other oral or other agreements between the parties that have not been incorporated into this Amendment and the Agreement.

4. Each of the persons signing this Amendment represents and warrants that he/she is a duly authorized officer, director or agent of the party on whose behalf the person is signing, and further represents and warrants that the person signing has the power and authority to bind the party, and that the party has the legal power to enter into this Amendment.

United Behavioral Health

Signature: Leslie J. Davis
Leslie J. Davis (Feb 5, 2014)

Print Name: Leslie J. Davis

UnitedHealthcare of Louisiana, Inc.

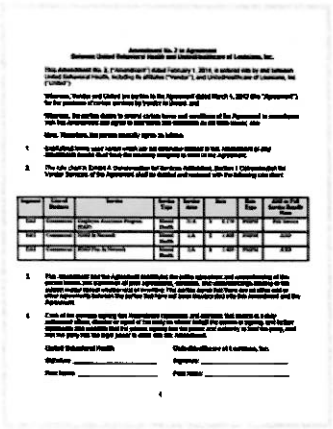
Signature: Bridget Galatas
Bridget Galatas (Jan 31, 2014)

Print Name: Bridget Galatas

Print Title: CFO

Print Title: Gulf States CFO

IIPAS No: 6088-C-000
Internal Control No.: 48449



UBH (6088-C) (R 6216-B) UHCLA (EI) AM02 020114 (48449) for sigs

EchoSign Document History February 05, 2014

Created:	January 09, 2014
By:	Mark Heuer (mark.heuer@optum.com)
Status:	SIGNED
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Document created by Mark Heuer (mark.heuer@optum.com)
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January 31, 2014 - 1:10 PM CST

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Document esigned by Leslie J. Davis (leslie.davis@optum.com)
Signature Date: February 05, 2014 - 1:45 PM CST - Time Source: server - IP address: 198.203.175.175

Signed document emailed to all eligible parties.
February 05, 2014 - 1:45 PM CST

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THIRD AMENDMENT
TO BEHAVIORAL HEALTH SERVICES AGREEMENT

This Third Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of January 1, 2015 (the "Effective Date") by and between United Behavioral Health ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012 (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. The attached "Exchange Regulatory Appendix" is hereby added as Exhibit **G**. The Exhibit list is amended to add X Exhibit G: Exchange Regulatory Appendix

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

United Behavioral Health

Signature: Leslie J. Davis (Dec 22, 2014)

Print Name: Leslie J. Davis

Print Title: CFO

UnitedHealthcare of Louisiana, Inc.

Signature: Bridget Galatas (Dec 9, 2014)

Print Name: Bridget Galatas

Print Title: CFO

Internal Control No.: 55890

EXHIBIT G

EXCHANGE REGULATORY APPENDIX

[SEE ATTACHED]

EXCHANGE REGULATORY APPENDIX

THIS EXCHANGE REGULATORY APPENDIX (this "Appendix") supplements and is made part of the Agreement and shall survive termination of the Agreement to the extent it or applicable law imposes continuing obligations.

SECTION 1
APPLICABILITY

United is operating as a certified Qualified Health Plan Issuer ("QHP Issuer") in one or more public Health Care Exchanges ("Exchange") created under the terms of the Federal Patient Protection and Affordable Care Act ("PPACA") and any implementing State law. United may be delegating certain of its QHP Issuer's activities, reporting responsibilities, and/or other obligations, to Vendor.

This Appendix applies solely to the services performed and provided with respect to any Exchange business delegated by United to Vendor pursuant to the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control, except as required by applicable law. Terms in this Agreement shall be as defined in PPACA, as supplemented by any applicable State Exchange law.

SECTION 2
PROVISIONS

This Appendix is intended to comply with Exchange laws and substantive requirements.

1. The delegated activities and reporting responsibilities are set forth in the Agreement to which this Appendix is attached. To the extent such delegated activities and reporting responsibilities serve Exchange business, they are designated as "QHP Services".

2. Vendor acknowledges and agrees that United may revoke the delegated activities and reporting standards of Vendor or specify other remedies, for the respective Exchange, in instances where the U.S. Department of Health and Human Services ("HHS"), a State Exchange regulator, or United determines that such parties have not performed satisfactorily. To the extent that HHS or a State Exchange regulator directs the revocation, United shall provide immediate written notice of such to Vendor, and such revocation shall become effective as directed by HHS or the State Exchange regulator. Vendor shall cooperate with United regarding the transition of any QHP Services that have been revoked by United.

3. Vendor must comply with all applicable laws and regulations relating to the standards specified in 45 CFR §156.340, as it may be amended from time to time, and all other Federal and/or State laws relevant to United's Exchange business being serviced.

4. Vendor must permit access by the Secretary of HHS and the Office of Inspector General or their designees, in the case of Federally Facilitated Exchange ("FFE") business, or comparable State regulators, in the case of State Exchange business, in connection with their right to evaluate through audit, inspection, or other means, to Vendor's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the United's obligations as a QHP Issuer in accordance with Federal standards under 45 CFR §156.340, as it may be amended from time to time, with all records retained for at least 10 years from the final date of the Agreement period or such lesser period which may be specified in State law for State Exchanges.

5. If submitting FFE data is involved, Vendor is bound by the terms of United's "Agreement between Qualified Health Plan Issuer and The Centers for Medicare and Medicaid Services" or any applicable trading partners or comparable State Exchange agreement, to test its software, and receive United's approval of software as being in the proper format and compatible with the FFE or the applicable State system.

6. If any State Exchange or HHS for FFEs requires additional specific provisions to be in United's agreement with any delegated or downstream entity, they will be provided to Vendor by United and are incorporated herein by reference or by attaching a copy of such provisions to this Exchange Regulatory Appendix.

7. If Vendor delegates any QHP Services to a downstream entity (as such term is defined in 45 C.F.R. §156.20), Vendor shall provide written advance notification to United of such delegated activities and reporting responsibilities before the applicable effective date of the delegation under federal regulations, Vendor shall bind the downstream entity to all the terms of this Appendix, including providing for revocation of the delegated activities.

FOURTH AMENDMENT
TO BEHAVIORAL HEALTH SERVICES AGREEMENT

This Fourth Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of April 1, 2015 (the "Effective Date") by and between United Behavioral Health ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012 (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit **A** "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit **A** "Compensation for Services Addendum", attached hereto.

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

United Behavioral Health

Signature: Lloyd Dyer (Mar 25, 2015)

Print Name: Lloyd Dyer

Print Title: COO, OHBS

UnitedHealthcare of Louisiana, Inc.

Signature: Eric H Johnson (Feb 23, 2015)

Print Name: Eric H Johnson

Print Title: CFO UnitedHealthcare LA - E&I

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area	Rate	Rate Type	ASO or Full Service Benefit Plans
E&I	Commercial	Employee Assistance Program (EAP)	Mental Health	-	[redacted]	PMPM	ASO
E&I	Commercial	HMO In Network	Mental Health	-	[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Mental Health	-	[redacted]	PMPM	ASO

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

FIFTH AMENDMENT
TO THE BEHAVIORAL HEALTH SERVICES AGREEMENT

This Fifth Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of December 1, 2015 (the "Amendment Effective Date") by and between United Behavioral Health, 425 Market Street, 14th Floor, San Francisco, CA 94105 ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby amended by adding additional rates as set forth below:

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	Medicaid - Acute Non-Disabled Adult - >/= 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Acute Non-Disabled Adult - >/= 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Acute Non-Disabled Adult - >/= 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Acute Non-Disabled Adult - >/= 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Acute Non-Disabled Child - < 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Acute Non-Disabled Child - < 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO

C&S	Medicaid	Medicaid - Acute Non-Disabled Child - < 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Acute Non-Disabled Child - < 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Adult - >/= 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Adult - >/= 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Adult - >/= 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Adult - >/= 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Child - < 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Child - < 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Child - < 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Behavioral Only Non-Disabled Child - < 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	South Central Region	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Acute Disabled Adult - >/= 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Acute Disabled Adult - >/= 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Acute Disabled Adult - >/= 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Acute Disabled Adult - >/= 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Acute Disabled Child - < 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Acute Disabled Child - < 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO

C&S	Medicaid	SSI - Acute Disabled Child - < 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Acute Disabled Child - < 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Adult - >/= 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Adult - >/= 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Adult - >/= 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Adult - >/= 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Child - < 21 Years	Behavioral Health	North Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Child - < 21 Years	Behavioral Health	Gulf Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Child - < 21 Years	Behavioral Health	Capital Region	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Behavioral Only Disabled Child - < 21 Years	Behavioral Health	South Central Region	[redacted]	PMPM	ASO

3. The attached “Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix” is hereby added as Exhibit E. The Exhibit list is amended to add an “X” to indicate an Exhibit E is included.

4. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

United Behavioral Health	**UnitedHealthcare of Louisiana, Inc.**
Signature: Joel Costa (Jun 27, 2016)	Signature: Eric H Johnson (Jun 27, 2016)
Print Name: Joel Costa	Print Name: Eric H Johnson
Print Title: VP Finance & CFO	Print Title: CFO Unitedhealthcare E&I - Louisiana

EXHIBIT E

SPECIFIC STATE PROGRAM

REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the Subcontract between UnitedHealthcare Insurance Company, contracting on behalf of itself or one of its Affiliates (collectively, "United") and Subcontractor.

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the State of Louisiana's Bayou Health and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company. UnitedHealthcare of Louisiana, Inc. is an Affiliate.

2.2 **Covered Person:** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or DHH:** The Louisiana Department of Health and Hospitals.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract(s) with DHH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Bayou Health and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Covered Services; Definitions Related to Coverage. Provider shall follow the State Contract's requirements for the provision of Covered Services. A description of the package of benefits offered by DHH under the State Program is available on the DHH website at http://www.makingmedicaidbetter.com/. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be based on the individual's medical needs and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR Part 438.114(a) and § 1932(b)(2) of the Social Security Act of 1935 (42 U.S.C. §

1396u-2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition. Emergency Services also include services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). There are no prior authorization requirements for Emergency Services.

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial or non-Medicaid/CHIP members or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and

obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. Subcontractor and Provider shall accept the final payment made by United as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the Covered Persons(s). Covered Person shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. At all times during the Agreement, Subcontractor shall, and shall ensure Provider indemnifies, defends, protects, and holds harmless DHH and any of its officers, agents, and employees from:

(a) Any claims, losses, or suits relating to activities undertaken by Subcontractor and/or Provider pursuant to the Agreement or pursuant to the State Contract;

(b) Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for Subcontractor and/or Provider in connection with performance of the Agreement or in connection with performance of the State Contract;

(c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Provider and/or Subcontractor, its agents, officers, employees, or contractors in performance of the Agreement or in performance of the State Contract;

(d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor and/or Provider, its agents, officers, employees, or contractors, by Subcontractor's and/or Provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the State Contract, or by federal or State regulations or statutes;

(e) Any failure of Subcontractor and/or Provider, its agents, officers, employees, or contractors, to observe federal or State laws, including but not limited to labor laws and minimum wage laws;

(f) Any claims for damages, losses, or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

(g) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor and/or Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of United, Subcontractor, Provider, or DHH (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), United, Subcontractor, Provider, or DHH will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the State Contract remains in full force and effect, United shall be liable for authorizing services required in accordance with the State Contract.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records,

to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, DHH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Retention. Subcontractor shall, and shall require Provider to retain all administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by DHH (whether paper or electronic) for the later of: (i) six (6) years from the expiration date of the State Contract, including any extension(s) thereof; or (ii) for Covered Person records, for six (6) years after the last payment was made for services provided to the Covered Person (an exception to this requirement includes records pertaining to once in a lifetime events, including but not limited to appendectomy and amputations, etc., which must be retained indefinitely and may not be destroyed); or (iii) such other period as required by law. Notwithstanding the foregoing, if the records are under review or audit or related to any matter in litigation, such records shall be retained until completion of the audit, review or litigation and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

The above record retention requirements pertain to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least six (6) years, commencing from the last date of treatment.

(d) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to DHH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Inspection, Audit and Evaluation

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that DHH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the

quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as often as they may deem necessary during the State Contract period and for a period of six (6) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

(b) By DHH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require that Provider understand that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not

identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Subcontractor shall, and shall require Provider to notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract and DHH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract and DHH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and DHH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the DHH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's and/or Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.11 Excluded Individuals. By signing the Agreement, Subcontractor certifies, and shall require Provider to certify to the best of Subcontractor's and Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under either § 1128 or § 1128A of the Social Security Act;

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion

information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. United will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

4.12 Cultural Competency. Subcontractor shall, and shall require Provider to deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Subcontractor shall, and shall require Provider to take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Agreement must be submitted to United to submit to the Department for prior approval. In addition, Subcontractor shall, and shall require Provider to comply with the State Contract's requirements related to marketing communications.

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist DHH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network, employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA)
Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies,

detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Outstanding Claim Information. In the event of termination of the Agreement, Subcontractor shall, and shall require Provider to promptly supply to United or its designee all information necessary for the reimbursement of any outstanding Medicaid claims.

4.16 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.17 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in DHH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information.

4.18 Quality Assessment/Utilization Management Review. Subcontractor shall, and shall require Provider to adhere to the State Program's Quality Assessment and Performance Improvement (QAPI) program requirements, as outlined in the State Contract and the Quality Companion Guide, which are incorporated herein by reference and shall be furnished to Subcontractor and/or Provider upon request. Subcontractor shall, and shall require Provider to cooperate with United's QAPI and utilization management (UM) programs, which adhere to all DHH QAPI and UM program requirements. Subcontractor agrees, and shall require Provider to agree to participate and cooperate in any internal or external quality assessment review, utilization management, or grievance procedures established by United and/or the Department or its designee, whether such review or procedures are announced or unannounced.

4.19 Insurance. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. DHH and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider.

4.20 Licensing Requirements. Subcontractor represents, and shall require that Provider represent that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate Louisiana licensing body or standard-setting agency, as

applicable. Subcontractor represents, and shall require that Provider represent that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Subcontractor represents, and shall require Provider to represent that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the Office of the Louisiana Attorney General. Subcontractor shall, and shall require Provider to maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Subcontractor and Provider by United under the Agreement. If at any time during the term of the Agreement, Subcontractor and/or Provider are not properly licensed as described in this Section, Subcontractor shall, and shall require Provider to discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

4.21 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.22 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United.

4.23 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.24 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.25 Data and Reports. Subcontractor shall, and shall ensure Provider submits to United all reports and clinical information which United or DHH may require for reporting purposes pursuant to the State Contract, including but not limited to encounter data, HEDIS, AHRQ and EPSDT data and reports, where applicable. Provider shall utilize DHH's Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations. As applicable, if United has entered into alternative reimbursement arrangements with Subcontractor and/or Provider (with prior approval

by the Department), Subcontractor and Provider are required to submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by United. NOTE: United is not allowed to enter into alternative reimbursement arrangements with FQHCs or RHCs.

4.26 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or DHH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 180 days from the date of service.

4.27 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.28 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by DHH.

4.29 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the scope of Subcontractor's and/or Provider's practice.

4.30 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.31 Appeals and Grievances. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with DHH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have correct and adequate supply of such public notices.

4.32 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that DHH has the right to direct United to impose financial

consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

4.33 Primary Care Provider ("PCP") Linkages. If Provider is a PCP, Subcontractor shall require Provider to stipulate by signing an agreement that Provider's total number of Medicaid/CHIP members for the State Program will not exceed 2,500 lives per full-time physician or 1,000 lives per mid-level practitioner or physician extender up to a cap of 2,500 lives. Prior to executing an Agreement, Subcontractor, Provider and United shall specify the number of linkages United may link to Provider.

4.34 Birth Registration. As applicable, Subcontractor shall ensure Provider registers all births through LEERS (Louisiana Electronic Event Registration System) administered by the DHH/Vital Records Registry. Hospital Providers must notify United and DHH of the birth of a newborn when the mother is a member of United, complete the web-based DHH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to DHH.

4.35 Laboratory Services. If Provider performs laboratory services, Subcontractor shall ensure Provider meets all applicable State and federal requirements, including but not limited to 42 CFR Sections 493.1 and 493.3, as may be amended from time to time. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Subcontractor shall require that Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Subcontractor shall further ensure Provider provides a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

4.36 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall ensure Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Agreement. Subcontractor understands, and shall ensure Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.37 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

4.38 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

4.39 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

4.40 Advance Directives. Subcontractor shall, and shall ensure Provider complies with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

4.41 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

3.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and applicants.

3.43 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

SECTION 5
UNITED REQUIREMENTS

5.1 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract

if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6
OTHER REQUIREMENTS

6.1 State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any requirement or provision of the Agreement or this Appendix is determined by DHH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Agreement and this Appendix shall remain in full force and effect.

6.2 Ongoing Monitoring. As required under the State Contract, United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Agreement and shall perform periodic formal reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or DHH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established by DHH in the State Contract and DHH-issued guides.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of DHH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and DHH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that DHH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the State Contract. United will submit and obtain prior approval from DHH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of DHH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 Health Care-Acquired/Preventable Conditions. United and Subcontractor acknowledge and agree that United is prohibited from making payments to Subcontractor for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by DHH.

6.10 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.11 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor

acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by DHH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

6.12 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.13 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.16 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

SIXTH AMENDMENT
TO THE BEHAVIORAL HEALTH SERVICES AGREEMENT

This Sixth Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of November 1, 2017 (the "Amendment Effective Date") by and between United Behavioral Health, 425 Market Street, 14th Floor, San Francisco, CA 94105 ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

United Behavioral Health

Signature: DocuSigned by: Joel Costa 9CE2139664E4446...

Print Name: Joel Costa

Print Title: CFO

UnitedHealthcare of Louisiana, Inc.

Signature: Eric H. Johnson

Print Name: Eric H. Johnson

Print Title: CFO

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

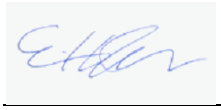
United Behavioral Health

Signature: _____

Print Name: _____

Print Title: _____

UnitedHealthcare of Louisiana, Inc.

Signature: 

Print Name: Eric H. Johnson

Print Title: CFO

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	ACA Medicaid Expansion	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	Child Health Plus (CHP)	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO

C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-12 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-12 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-12 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-12 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Adult >/= 21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Adult >/= 21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Adult >/= 21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Adult >/= 21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO

C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Child < 21 Years - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Child < 21 Years - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Child < 21 Years - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Child < 21 Years - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Child < 21 Years	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicare	Special Needs Plan (SNP) Dual	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 0-2 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 0-2 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 0-2 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 0-2 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 3-12 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 3-12 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO

C&S	Medicaid	SSI - 3-12 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 3-12 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
E&I	Commercial	Employee Assistance Program (EAP)	Behavioral Health		[redacted]	PMPM	FULL SERVICE
E&I	Commercial	HMO In Network	Behavioral Health		[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Behavioral Health		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15th) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter or longer than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

SEVENTH AMENDMENT
TO THE BEHAVIORAL HEALTH SERVICES AGREEMENT

This Seventh Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of November 1, 2018 (the "Amendment Effective Date") by and between United Behavioral Health ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

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IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

United Behavioral Health

Signature: DocuSigned by: John Rimstad 4074228894614F9...

Print Name: John Rimstad

Print Title: Director Finance

UnitedHealthcare of Louisiana, Inc.

Signature: DocuSigned by: Michael J. Balcer 59ED99BC9F0C434...

Print Name: Michael J. Balcer

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

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C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Male	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Male	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Male	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Male	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 19-24 Years - Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO

C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Male	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Male	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Male	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Male	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 25-39 Years - Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years - Male	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years - Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years - Male	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years - Male	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years - Male	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years - Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years - Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 40-49 Years	Behavioral Health	North	[redacted]	PMPM	ASO

		– Female					
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Male	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Male	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Male	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ACA Medicaid Expansion - 50-64 Years - Male	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Child Health Plus (CHP) - LaCHP Affordable Plan	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Child Health Plus (CHP) - LaCHP Affordable Plan	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Child Health Plus (CHP) - LaCHP Affordable Plan	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Child Health Plus (CHP) - LaCHP Affordable	Behavioral Health	South Central	[redacted]	PMPM	ASO

		Plan					
C&S	Medicaid	Child Health Plus (CHP) - LaCHP Affordable Plan - ABA Add-on	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - ABA Add-on	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Medicaid Members	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 0-2 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-11 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - 3-11 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Adult >/= 21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus	Behavioral	North	[redacted]	PMPM	ASO

		(FHP) - Adult >/= 21 Years	Health				
C&S	Medicaid	Family Health Plus (FHP) - Adult >/= 21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Adult >/= 21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years - Kids	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years - Kids	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years - Kids	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years - Kids	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years - Kids - ABA Add-on	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years - Kids - ABA Add-on	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family Health Plus (FHP) - Child > 1 and < 21 Years - Kids - ABA Add-on	Behavioral Health	North	[redacted]	PMPM	ASO
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C&S	Medicaid	Foster Care - ABA Add-on	Behavioral Health		[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care	Behavioral Health	Capital	[redacted]	PMPM	ASO
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C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
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C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Adult >/= 21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver - Child < 21 Years - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
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C&S	Medicaid	Medicaid	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Special Needs Plan (SNP) Dual	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Special Needs Plan (SNP) Dual	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Special Needs Plan (SNP) Dual	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Special Needs Plan (SNP) Dual	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 3-11 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Adult >/= 21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids - ABA Add-on	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids - ABA Add-on	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids - ABA	Behavioral Health	North	[redacted]	PMPM	ASO

		Add-on					
C&S	Medicaid	SSI - Child > 1 and < 21 Years - Kids - ABA Add-on	Behavioral Health	South Central	[redacted]	PMPM	ASO
E&I	Commercial	Employee Assistance Program (EAP)	Behavioral Health		[redacted]	PMPM	FULL SERVICE
E&I	Commercial	HMO In Network	Behavioral Health		[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Behavioral Health		[redacted]	PMPM	ASO
M&R	Medicare	Medicare Advantage	Behavioral Health		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15th) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter or longer than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

EIGHTH AMENDMENT
TO THE BEHAVIORAL HEALTH SERVICES AGREEMENT

This Eighth Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of December 1, 2019 (the "Amendment Effective Date") by and between United Behavioral Health,425 Market Street, 14th Floor, San Francisco, CA 94105 ("Vendor") and UnitedHealthCare of Louisiana, Inc., 3838 North Causeway Boulevard Suite 2600, Metairie, LA 70002 ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

1. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

2. Exhibit C, "Medicare Advantage Regulatory Requirements Appendix" to the Agreement is hereby deleted in its entirety and replaced with the Exhibit C, "Medicare Advantage Regulatory Requirements Appendix," attached hereto.

3. Exhibit E "Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix" is hereby deleted in its entirety and replaced with Exhibit E, "Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix," attached hereto.

4. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

United Behavioral Health

Signature: DocuSigned by: Matthew J Hedman 87F32663040E440...

Print Name: Matthew J Hedman

Print Title: Vice President

UnitedHealthCare of Louisiana, Inc.

Signature: DocuSigned by: Michael J. Balcer 59ED99BC9F0C434...

Print Name: Michael J. Balcer

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ABD Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible,	Behavioral Health	Capital	[redacted]	PMPM	ASO

		All Ages -Behavioral Only					
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ABD Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ABD Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO

C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH Male and Female - Behavioral Only <21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH Male and Female - Behavioral Only <21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH Male and Female - Behavioral Only - <21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH Male and Female - Behavioral Only <21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver Male	Behavioral	North	[redacted]	PMPM	ASO

		and Female - <21 Years	Health				
C&S	Medicaid	HCBS Waiver Male and Female - <21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver Male and Female - <21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver Male and Female - <21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Child, 1-20 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Child, 1-20 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 19 -24 - EXPANSION	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 19 -24 - EXPANSION	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 19 -24 - EXPANSION	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 19 -24 - EXPANSION	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 19-24 -	Behavioral	Capital	[redacted]	PMPM	ASO

		EXPANSION	Health				
C&S	Medicaid	Male Age 19-24 - EXPANSION	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 19-24 - EXPANSION	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 19-24 - EXPANSION	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children	Behavioral	Capital	[redacted]	PMPM	ASO

		Adult, 21+ Years	Health				
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 25-39	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 25-39	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 25-39	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 25-39	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 25-39	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 25-39	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 25-39	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 25-39	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Newborn, 3-11 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Newborn, 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Newborn, 3-11 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 40-49 - EXPANSION	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 40-49 - EXPANSION	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 40-49 -	Behavioral	South	[redacted]	PMPM	ASO

		EXPANSION	Health	Central			
C&S	Medicaid	Male Age 40-49 - EXPANSION	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 40-49 - EXPANSION	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 40-49 - EXPANSION	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 40-49 - EXPANSION	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 40-49 - EXPANSION	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 50-64 - EXPANSION	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 50-64 - EXPANSION	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 50-64 - EXPANSION	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 50-64 - EXPANSION	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 50-64 - EXPANSION	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 50-64 - EXPANSION	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Female Age 50-64 - EXPANSION	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Male Age 50-64 - EXPANSION	Behavioral Health	Gulf	[redacted]	PMPM	ASO
E&I	Commercial	Employee Assistance Program (EAP)	Behavioral Health		[redacted]	PMPM	FULL SERVICE
E&I	Commercial	HMO In Network	Behavioral Health	LA	[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Behavioral Health	LA	[redacted]	PMPM	ASO
M&R	Medicare	Medicare Advantage	Behavioral Health	LA	[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

EXHIBIT C

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
MEDICAL VENDOR

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX ("Appendix") supplements and is made part of the agreement ("Agreement") with United Behavioral Health, Inc. ("Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies to the services provided by Subcontractor pursuant to the Agreement as such services relate to the provision of Covered Services to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

2.1 Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

2.2 CMS Contract: A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 Cost Sharing: Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

2.4 Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

2.5 Customer: A person eligible and enrolled to receive coverage from a Payer for Covered Services.

2.6 Dual Eligible Customer: A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 Medicare Advantage Customer or MA Customer: A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan that is covered under the Agreement.

2.9 Medicare Advantage Organization or MA Organization: For purposes of this Appendix, MA Organization is: (a) UnitedHealthcare Insurance Company and/or one or more of its affiliates ("United") that has entered into a contract with CMS for the purpose of offering a Benefit Plan to MA Customers; or (b) Payer.

2.10 Participating Provider: A hospital, ancillary provider, physician group, individual physician, or other health care provider, duly licensed or authorized under the laws of the jurisdiction in which Covered Services are provided, who participates in MA Organization's network through a provider agreement or network participation agreement with Subcontractor.

2.11 Payer: An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized to access Participating Providers' services rendered pursuant to the Agreement.

SECTION 3
DELEGATED ACTIVITIES

3.1 MA Organization Accountability; Delegated Activities. Subcontractor acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization has delegated to Subcontractor under the Agreement. In addition to the other provisions of this Appendix, the following shall apply with respect to any functions and responsibilities under the CMS Contract that MA Organization has delegated to Subcontractor pursuant to the Agreement:

(a) Subcontractor shall perform or arrange for the provision of those delegated activities set forth in the Agreement.

(b) Subcontractor shall comply with any reporting responsibilities as set forth in the Agreement.

(c) If MA Organization has delegated to Subcontractor any activities related to the credentialing of health care providers, Subcontractor must comply with all applicable CMS requirements for credentialing including, but not limited to, the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the credentialing process must be reviewed, preapproved, and audited on an ongoing basis by MA Organization.

(d) If MA Organization has delegated to Subcontractor the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, or the selection of contractors or subcontractors to perform services under the CMS Contract, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers and the agreements with such contractors or subcontractors.

(e) Subcontractor acknowledges that MA Organization shall monitor Subcontractor's performance of delegated activities on an ongoing basis. Such monitoring activities may include site visits and periodic audits. If CMS or MA Organization determines that Subcontractor has not performed satisfactorily, or has failed to meet all reporting and disclosure requirements in a timely manner, MA Organization may revoke any or all of the delegated activities and reporting requirements. Subcontractor shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

SECTION 4
SUBCONTRACTOR AND PARTICIPATING PROVIDER REQUIREMENTS

4.1 Data. Subcontractor shall and/or shall require Participating Providers to, submit to MA Organization all risk adjustment data as defined in 42 CFR § 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Subcontractor and Participating Providers represent to MA Organization, and upon MA Organization's request, shall certify in writing, that the data is accurate, complete, and truthful, based on Subcontractor's or Participating Providers' best knowledge, information and belief.

4.2 Policies. Subcontractor shall, and shall require Participating Providers to, comply with MA Organization's policies and procedures.

4.3 Customer Protection. Subcontractor agrees, and shall require Participating Providers to agree, that in no event including, but not limited to, non-payment by Subcontractor, MA Organization or an intermediary, insolvency of Subcontractor, MA Organization or an intermediary, or breach by United of the

Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Participating Providers or on behalf of a network through which Participating Providers elect to participate. In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Subcontractor shall require Participating Providers to continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

4.4 Dual Eligible Customers. Subcontractor agrees, and shall require Participating Providers to agree, that in no event including, but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by United of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Subcontractor and Participating Providers will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Subcontractor or Participating Providers impose an excess charge on a Dual Eligible Customer, Subcontractor and Participating Providers are subject to any lawful sanction that may be imposed under Medicare or Medicaid.

4.5 Eligibility. Subcontractor agrees and shall require Participating Providers to agree to immediately notify MA Organization in the event Subcontractor or any Participating Provider is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Subcontractor shall not, and shall require Participating Providers not to employ or contract for the provision of health care services, utilization review, medical social work or administrative services, (collectively "Eligibility Services"), with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Subcontractor shall and shall require Participating Providers to review the Department of Health and Human Services Officer of Inspector General List of Excluded Individuals and Entities and the System for Award Management (SAM), a portal for the Federal Procurement System (or any successor listing of excluded individuals or entities) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member or subcontractor for the provision of Eligibility Services. Subcontractor must and must require Participating Providers to continue to review these lists on a monthly basis thereafter to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs. MA Customers shall not have any financial liability for services or items furnished by an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is included on the preclusion list under Part 422 of the Code of Federal Regulations.

4.6 Laws. Subcontractor shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.7 Federal Funds. Subcontractor acknowledges, and agrees to inform Participating Providers, that MA Organization receives federal payments under the CMS Contract and that payments Subcontractor or Participating Providers receive from or on behalf of MA Organization are, in whole or in part, from

federal funds. Subcontractor and Participating Providers are therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

4.8 CMS Contract. Subcontractor shall perform the services set forth in the Agreement in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract. Subcontractor shall also require that health care services rendered to MA Customers by Participating Providers pursuant to the Agreement are performed in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract.

4.9 Records.

(a) Privacy and Confidentiality; Customer Access. Subcontractor shall safeguard MA Customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, including the requirements established by MA Organization and the Medicare Advantage program, as applicable. Subcontractor shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law. Subcontractor shall require Participating Providers to comply with all the requirements in this section with respect to records and information related to health care services provided by Participating Providers to MA Customers pursuant to the Agreement.

(b) Retention. Subcontractor shall maintain records and information related to the services provided by Subcontractor under the Agreement including, but not limited to, MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Subcontractor shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all other records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

(c) Government Access to Records. Subcontractor acknowledges and agrees that the U.S. Department of Health and Human Services, the Comptroller General, or their designees shall have the right (directly or through the MA Organization) to audit, evaluate, collect, and inspect any pertinent books, contracts, computer or other electronic systems (including medical records and documentation), and other records and information of Subcontractor and Participating Providers related to the CMS Contract. Subcontractor shall, and shall require Participating Providers to, make available its premises, physical facilities, and equipment, records relating to MA Customers and any additional relevant information CMS may require. This right shall extend through the longer of the time periods identified in subsection 4.9(b)(i) and (ii), or ten (10) years from date of completion of any audit, whichever is later in time.

(d) MA Organization Access to Records. Subcontractor shall, and shall require Participating Providers to, grant MA Organization or its designees such audit, evaluation, collection and inspection rights identified in subsection 4.9(c) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Subcontractor and Participating Providers reasonable notice of the need for such audit, evaluation, collection, or inspection, and will conduct such audit, evaluation, collection, or inspection at a reasonable time and place. Subcontractor shall, and shall require Participating Providers to, submit medical records of MA Customers to the MA Organization as may be

requested, within the timeframes specified, for (i) the purpose of CMS audits of risk adjustment data, and (ii) other purposes medical records from providers are used by MA Organization, as specified by CMS.

4.10 Subcontracts. If Subcontractor has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries or any other subcontractors, directly or through another person or entity, to perform any of the services Subcontractor is obligated to perform under the Agreement that are the subject of this Appendix, Subcontractor shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Subcontractor shall provide proof of such to MA Organization upon request. In addition, Subcontractor agrees to oversee and monitor, on an ongoing basis, the services Subcontractor has subcontracted to another person or entity. Subcontractor further agrees to promptly amend its agreements with such subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization, to meet any additional CMS requirements that may apply to the services. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.11 Offshoring. Unless previously authorized by MA Organization in writing, All services provided by Subcontractor pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories. The following provisions apply to Medicare-related services that involve Medicare beneficiary protected health information ("PHI") performed pursuant to the Agreement at locations outside of one of the fifty United Sates, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands):

(a) Subcontractor represents and warrants to MA Organization that Subcontractor has in place and will comply with policies and procedures to ensure that all PHI and other personal information remains secure. Subcontractor will provide written evidence of the policies and procedures upon MA Organization's request.

(b) Subcontractor will provide prior written notice to MA Organization of (a) any material change in the Medicare-related services that involve PHI that Subcontractor performs offshore, (b) any material change in Subcontractor's policies and procedures to ensure that all PHI and other personal information remains secure, and (c) any material change in the tools and systems used by Subcontractor to ensure that all PHI and other personal information remains secure.

(c) Subcontractor is prohibited from receiving access to any PHI or other personal information of MA Customers that is not associated with services performed and products provided by Subcontractor pursuant to the Agreement. If Subcontractor receives access to PHI or other personal information of MA Customers that is not associated with Subcontractor's services performed and products provided by Subcontractor pursuant to the Agreement, Subcontractor will immediately notify MA Organization that it has received such access, return all PHI or personal information accessed by Subcontractor, and destroy any such PHI or personal information that remains in Subcontractor's possession after doing so (i.e. copies, electronic records, back-ups or temporary files).

(d) Subcontractor's services under the Agreement may be terminated immediately upon discovery of a significant security breach.

(e) Subcontractor authorizes MA Organization or its designee to conduct an audit of Subcontractor's offshore activities at least annually.

(f) Subcontractor acknowledges and agrees that MA Organization will use the results of its audit of Subcontractor to evaluate the continuation of MA Organization's relationship with Subcontractor.

(g) Subcontractor authorizes MA Organization or its designee to share the results of audits of Subcontractor with CMS.

SECTION 5
OTHER

5.1 Payment. MA Organization or its designee shall promptly process and pay or deny a Participating Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Subcontractor or Participating Providers are responsible for making payment to subcontracted providers for services provided to MA Customers, Subcontractor shall, and shall require Participating Providers to, promptly process and pay or deny such providers no later than sixty (60) days after Subcontractor or a Participating Provider receives request for payment for those services from subcontracted providers.

5.2 Regulatory Amendment. MA Organization may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, CMS. MA Organization shall provide written or electronic notice to Subcontractor of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Subcontractor will not be required in order for the amendment to take effect.

5.3 Survivability. The terms of this Appendix shall survive the termination of the Agreement regardless of the reason for termination.

EXHIBIT E

STATE REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Subcontract") between UnitedHealthcare of Louisiana, Inc. ("United") and subcontractor named in the agreement to which this Appendix is attached (the "Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the Louisiana Healthy Louisiana and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Agreement:** An executed contract between Subcontractor and a Provider for the provision of Covered Services to persons enrolled in the State Program(s).

2.2 **Covered Person(s):** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement and/or Subcontract.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or LDH:** The Louisiana Department of Health.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement with Subcontractor for the provision of Covered Services to Covered Persons.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract(s) with LDH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Healthy Louisiana and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Covered Services; Definitions Related to Coverage. Provider shall follow the State Contract's requirements for the provision of Covered Services. A description of the package of benefits offered by LDH under the State Program is available on the LDH website at http://www.makingmedicaidbetter.com/. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be based on the individual's medical needs and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR Part 438.114(a) and § 1932(b)(2) of the Social Security Act of 1935 (42 U.S.C. § 1396u-2) and that are needed to screen, evaluate, and stabilize an Emergency

Medical Condition. Emergency Services also include services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). There are no prior authorization requirements for Emergency Services.

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial or non-Medicaid/CHIP members or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

3.3 Antitrust. Provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any State Program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Louisiana Health. For purposes of this assignment clause, "Provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's

relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. Subcontractor and Provider shall accept the final payment made by United as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the Covered Persons(s). Covered Person shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. At all times during the Agreement, Subcontractor shall, and shall ensure Provider indemnifies, defends, protects, and holds harmless LDH and any of its officers, agents, and employees from:

(a) Any claims, losses, or suits relating to activities undertaken by Subcontractor and/or Provider pursuant to the Agreement or pursuant to the State Contract;

(b) Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for Subcontractor and/or Provider in connection with performance of the Agreement or in connection with performance of the State Contract;

(c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Provider and/or Subcontractor, its agents, officers, employees, or contractors in performance of the Agreement or in performance of the State Contract;

(d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor and/or Provider, its agents, officers, employees, or contractors, by Subcontractor's and/or Provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the State Contract, or by federal or State regulations or statutes;

(e) Any failure of Subcontractor and/or Provider, its agents, officers, employees, or contractors, to observe federal or State laws, including but not limited to labor laws and minimum wage laws;

(f) Any claims for damages, losses, or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

(g) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against LDH or its agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor and/or Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of United, Subcontractor, Provider, or LDH (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), United, Subcontractor, Provider, or LDH will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the State Contract remains in full force and effect, United shall be liable for authorizing services required in accordance with the State Contract.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records, to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, LDH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Retention. Subcontractor shall, and shall require Provider to retain all administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by LDH (whether paper or electronic) for the later of: (i) ten (10) years from the expiration date of the State Contract, including any extension(s) thereof; or (ii) for Covered Person records, for ten (10) years after the last payment was made for services provided to the Covered Person (an exception to this requirement includes records pertaining to once in a lifetime events, including but not limited to appendectomy and amputations, etc., which must be retained indefinitely and may not be destroyed); or (iii) such other period as required by law. Notwithstanding the foregoing, if the records are under review or audit or related to any matter in litigation, such records shall be retained until completion of the audit, review or litigation and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

The above record retention requirements pertain to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least ten (10) years, commencing from the last date of treatment.

(d) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to LDH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Inspection, Audit and Evaluation

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana

Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as often as they may deem necessary during the State Contract period and for a period of ten (10) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

(b) By LDH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of LDH.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require that Provider understand that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Subcontractor will require that Provider further acknowledge that, in some cases, Provider will have access to information on individuals with whom Provider has no treatment or other relationship. In such cases Provider will abide by all requirements under HIPAA and ensure that the confidentiality of such information is fully maintained.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with the Agreement and Subcontract, including the U.S. Department of Health and Human

Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Subcontractor shall, and shall require Provider to notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract and LDH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract and LDH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and LDH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the LDH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and

nondiscrimination. If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's and/or Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.11 Excluded Individuals. By signing the Agreement, Subcontractor certifies, and shall require Provider to certify to the best of Subcontractor's and Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under either § 1128 or § 1128A of the Social Security Act;

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. United will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

4.12 Cultural Competency. Subcontractor shall, and shall require Providers to deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 § CFR 438.206(c)(2). Subcontractor shall and shall require Providers to ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Subcontractor shall, and shall require Provider to take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Agreement must be submitted to United to submit to the Department for prior approval. In addition, Subcontractor shall, and shall require Provider to comply with the State Contract's requirements related to marketing communications.

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist LDH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network,

employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA)
Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Outstanding Claim Information. In the event of termination of the Agreement, Subcontractor shall, and shall require Provider to promptly supply to United or its designee all information necessary for the reimbursement of any outstanding Medicaid claims.

4.16 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.17 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in LDH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information.

4.18 Quality Assessment/Utilization Management Review. Subcontractor shall, and shall require Provider to adhere to the State Program's Quality Assessment and Performance Improvement (QAPI) program requirements, as outlined in the State Contract and the Quality Companion Guide, which are incorporated herein by reference and shall be furnished to Subcontractor and/or Provider upon request. Subcontractor shall, and shall require Provider to cooperate with United's QAPI and utilization management (UM) programs, which adhere to all LDH QAPI and UM program requirements. Subcontractor agrees, and shall require Provider to agree to participate and cooperate in any internal or external quality assessment review, utilization management, or grievance procedures established by United and/or the Department or its designee, whether such review or procedures are announced or unannounced.

4.19 Insurance. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. LDH and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider.

4.20 Licensing Requirements. Subcontractor represents, and shall require that Provider represent that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate Louisiana licensing body or standard-setting agency, as applicable. Subcontractor represents, and shall require that Provider represent that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Subcontractor represents, and shall require Provider to represent that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the Office of the Louisiana Attorney General. Subcontractor shall, and shall require Provider to maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Subcontractor and Provider by United under the Agreement. If at any time during the term of the Agreement, Subcontractor and/or Provider are not properly licensed as described in this Section, Subcontractor shall, and shall require Provider to discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

4.21 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.22 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United.

4.23 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.24 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.25 Data and Reports. Subcontractor shall, and shall ensure Provider submits to United all reports and clinical information which United or LDH may require for reporting purposes pursuant to the State Contract, including but not limited to encounter data, HEDIS, AHRQ and EPSDT data and reports, where applicable. Provider shall utilize LDH's Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations. As applicable, if United has entered into alternative reimbursement arrangements with Subcontractor and/or Provider (with prior approval by the Department), Subcontractor and Provider are required to submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by United. NOTE: United is not allowed to enter into alternative reimbursement arrangements with FQHCs or RHCs.

4.26 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or LDH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

If Provider discovers an error or a conflict with a previously adjudicated encounter claim, Subcontractor and/or Health Plan shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or if circumstances exist that prevent Subcontractor and/or Health Plan from meeting this time frame a specified date shall be approved by LDH.

When Subcontractor has entered into an alternative reimbursement arrangement with Provider, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the Subcontractor.

4.27 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.28 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by LDH.

4.29 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the

services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the scope of Subcontractor's and/or Provider's practice.

4.30 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.31 Appeals and Grievances. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with LDH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have correct and adequate supply of such public notices.

4.32 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH has the right to direct United to impose financial consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

4.33 Primary Care Provider ("PCP") Linkages. If Provider is a PCP, Subcontractor shall require Provider to stipulate by signing an agreement that Provider's total number of Medicaid/CHIP members for the State Program will not exceed 2,500 lives per full-time physician or 1,000 lives per mid-level practitioner or physician extender up to a cap of 2,500 lives. Prior to executing an Agreement, Subcontractor, Provider and United shall specify the number of linkages United may link to Provider.

4.34 Birth Registration. As applicable, Subcontractor shall ensure Provider registers all births through LEERS (Louisiana Electronic Event Registration System) administered by the LDH/Vital Records Registry. Hospital Providers must notify United and LDH of the birth of a newborn when the mother is a member of United, complete the web-based LDH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to LDH.

4.35 Laboratory Services. If Provider performs laboratory services, Subcontractor shall ensure Provider meets all applicable State and federal requirements, including but not limited to 42 CFR

Sections 493.1 and 493.3, as may be amended from time to time. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Subcontractor shall require that Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Subcontractor shall further ensure Provider provides a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

4.36 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall ensure Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Agreement. Subcontractor understands, and shall ensure Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.37 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

4.38 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

4.39 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

4.40 Advance Directives. Subcontractor shall, and shall ensure Provider complies with the advance directives requirements for hospitals, nursing facilities, providers of home and health

care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

4.41 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

4.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and applicants.

4.43 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

4.44 Healthcare Oversight Agency Compliance. Subcontractor shall, and shall require Providers to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities that manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but do not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and United, Subcontractor or Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. United, Subcontractor and/or Provider agree that the State Contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

SECTION 5
UNITED REQUIREMENTS

5.1 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6

OTHER REQUIREMENTS

6.1 State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any requirement or provision of the Agreement or this Appendix is determined by LDH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Agreement and this Appendix shall remain in full force and effect.

6.2 Ongoing Monitoring. As required under the State Contract, United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Agreement and shall perform periodic formal reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or LDH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established by LDH in the State Contract and LDH-issued guides.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of LDH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and LDH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that LDH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the State Contract. United will submit and obtain prior approval from LDH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of LDH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 Health Care-Acquired/Preventable Conditions. United and Subcontractor acknowledge and agree that United is prohibited from making payments to Subcontractor for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by LDH.

6.10 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.11 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by LDH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The

date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

6.12 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.13 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that

it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.16 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

NINTH AMENDMENT
TO THE BEHAVIORAL HEALTH SERVICES AGREEMENT

This Ninth Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of March 1, 2020 (the "Amendment Effective Date") by and between United Behavioral Health, 425 Market Street, 14th Floor, San Francisco, CA 94105 ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012, as subsequently amended, (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Exhibit C, "Medicare Advantage Regulatory Requirements Appendix" to the Agreement is hereby deleted in its entirety and replaced with the Exhibit C, "Medicare Advantage Regulatory Requirements Appendix," attached hereto.

4. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

United Behavioral Health

DocuSigned by:

Signature: Matthew J Hedman
87F32663040E440...

Print Name: Matthew J Hedman

Print Title:

UnitedHealthcare of Louisiana, Inc.

DocuSigned by:

Signature: Collin S. McQuiddy
54CEE839CA27480...

Print Name: Collin S. McQuiddy

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	M/F Expansion	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	M/F Expansion	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	M/F Expansion	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	M/F Expansion	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH -	Behavioral Health	Gulf	[redacted]	PMPM	ASO

		Chisholm, All Ages Male & Female - Behavioral Only					
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical	Behavioral Health	Capital	[redacted]	PMPM	ASO

		Cancer BCC, All Ages Female					
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female - Behavioral Only	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages - Behavioral Only	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages	Behavioral Health	North	[redacted]	PMPM	ASO

		Female					
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children	Behavioral Health	North	[redacted]	PMPM	ASO

		Foster Care, All Ages Male & Female					
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - Male and Female - Behavioral Only <21 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - Male and Female - Behavioral Only <21 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - Male and Female - Behavioral	Behavioral Health	South Central	[redacted]	PMPM	ASO

		Only <21 Years					
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - Male and Female - Behavioral Only <21 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI	Behavioral	North	[redacted]	PMPM	ASO

		Child, 1-20 Years	Health				
C&S	Medicaid	ABD SSI Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Child, 1-20 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - Male and Female - Behavioral Only >21 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - Male and Female - Behavioral Only >21 Years	Behavioral Health	North, Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH	Behavioral Health	Capital	[redacted]	PMPM	ASO

		- Male and Female - Behavioral Only >21 Years					
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Newborn, 3-11 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Newborn, 3-	Behavioral Health	North	[redacted]	PMPM	ASO

		11 Months					
C&S	Medicaid	ABD SSI Newborn, 3-11 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	ABD SSI Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Male Age 25-39	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Male Age 25-39	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Male Age 25-39	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Male Age 25-39	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Female Age 25-39	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Female Age 25-39	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid - Female Age 25-39	Behavioral Health	Gulf	[redacted]	PMPM	ASO

C&S	Medicaid	Medicaid - Female Age 25-39	Behavioral Health	Capital	[redacted]	PMPM	ASO
E&I	Commercial	Employee Assistance Program (EAP) -	Behavioral Health		[redacted]	PMPM	FULL SERVICE
E&I	Commercial	HMO In Network	Behavioral Health	LA	[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Behavioral Health	LA	[redacted]	PMPM	ASO
M&R	Medicare	Medicare Advantage	Behavioral Health	LA	[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15th) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

EXHIBIT C

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

SEE ATTACHED

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
MEDICAL VENDOR

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX ("Appendix") supplements and is made part of the agreement ("Agreement") with United Behavioral Health ("Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies to the services provided by Subcontractor pursuant to the Agreement as such services relate to the provision of Covered Services to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

2.1 Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

2.2 CMS Contract: A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 Cost Sharing: Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

2.4 Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

2.5 Customer: A person eligible and enrolled to receive coverage from a Payer for Covered Services.

2.6 Dual Eligible Customer: A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 Medicare Advantage Customer or MA Customer: A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan that is covered under the Agreement.

2.9 Medicare Advantage Organization or MA Organization: For purposes of this Appendix, MA Organization is: (a) UnitedHealthcare Insurance Company and/or one or more of its affiliates ("United") that has entered into a contract with CMS for the purpose of offering a Benefit Plan to MA Customers; or (b) Payer.

2.10 Participating Provider: A hospital, ancillary provider, physician group, individual physician, or other health care provider, duly licensed or authorized under the laws of the jurisdiction in which Covered Services are provided, who participates in MA Organization's network through a provider agreement or network participation agreement with Subcontractor.

2.11 Payer: An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized to access Participating Providers' services rendered pursuant to the Agreement.

SECTION 3
DELEGATED ACTIVITIES

3.1 MA Organization Accountability; Delegated Activities. Subcontractor acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization has delegated to Subcontractor under the Agreement. In addition to the other provisions of this Appendix, the following shall apply with respect to any functions and responsibilities under the CMS Contract that MA Organization has delegated to Subcontractor pursuant to the Agreement:

(a) Subcontractor shall perform or arrange for the provision of those delegated activities set forth in the Agreement.

(b) Subcontractor shall comply with any reporting responsibilities as set forth in the Agreement.

(c) If MA Organization has delegated to Subcontractor any activities related to the credentialing of health care providers, Subcontractor must comply with all applicable CMS requirements for credentialing including, but not limited to, the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the credentialing process must be reviewed, preapproved, and audited on an ongoing basis by MA Organization.

(d) If MA Organization has delegated to Subcontractor the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, or the selection of contractors or subcontractors to perform services under the CMS Contract, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers and the agreements with such contractors or subcontractors.

(e) Subcontractor acknowledges that MA Organization shall monitor Subcontractor's performance of delegated activities on an ongoing basis. Such monitoring activities may include site visits and periodic audits. If CMS or MA Organization determines that Subcontractor has not performed satisfactorily, or has failed to meet all reporting and disclosure requirements in a timely manner, MA Organization may revoke any or all of the delegated activities and reporting requirements. Subcontractor shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

SECTION 4
SUBCONTRACTOR AND PARTICIPATING PROVIDER REQUIREMENTS

4.1 Data. Subcontractor shall and/or shall require Participating Providers to, submit to MA Organization all risk adjustment data as defined in 42 CFR § 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Subcontractor and Participating Providers represent to MA Organization, and upon MA Organization's request, shall certify in writing, that the data is accurate, complete, and truthful, based on Subcontractor's or Participating Providers' best knowledge, information and belief.

4.2 Policies. Subcontractor shall, and shall require Participating Providers to, comply with MA Organization's policies and procedures.

4.3 Customer Protection. Subcontractor agrees, and shall require Participating Providers to agree, that in no event including, but not limited to, non-payment by Subcontractor, MA Organization or an intermediary, insolvency of Subcontractor, MA Organization or an intermediary, or breach by United of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek

compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Participating Providers or on behalf of a network through which Participating Providers elect to participate. In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Subcontractor shall require Participating Providers to continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Subcontractor or Participating Providers and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

4.4 Dual Eligible Customers. Subcontractor agrees, and shall require Participating Providers to agree, that in no event including, but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by United of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Subcontractor and Participating Providers will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Subcontractor or Participating Providers impose an excess charge on a Dual Eligible Customer, Subcontractor and Participating Providers are subject to any lawful sanction that may be imposed under Medicare or Medicaid.

4.5 Eligibility. Subcontractor agrees and shall require Participating Providers to agree to immediately notify MA Organization in the event Subcontractor or any Participating Provider is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Subcontractor and Participating Providers shall not be eligible for payment from MA Organization after the date or during the time period specified by the applicable regulatory authorities. Subcontractor shall not, and shall require Participating Providers not to employ or contract for the provision of health care services, utilization review, medical social work or administrative services, (collectively "Eligibility Services"), with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Subcontractor shall and shall require Participating Providers to review the Department of Health and Human Services Officer of Inspector General List of Excluded Individuals and Entities and the System for Award Management (SAM), a portal for the Federal Procurement System (or any successor listing of excluded individuals or entities) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member or subcontractor for the provision of Eligibility Services. Subcontractor must and must require Participating Providers to continue to review these lists on a monthly basis thereafter to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs. MA Customers shall not have any financial liability and Subcontractor shall not and shall require Participating Providers not to pursue MA Customers for financial liability for services or items furnished by an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is included on the preclusion list under Part 422 of the Code of

Federal Regulations. Subcontractor and Participating Providers shall be financially liable for those services or items after the date or during the time period specified by the applicable regulatory authorities.

4.6 Laws. Subcontractor shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.7 Federal Funds. Subcontractor acknowledges, and agrees to inform Participating Providers, that MA Organization receives federal payments under the CMS Contract and that payments Subcontractor or Participating Providers receive from or on behalf of MA Organization are, in whole or in part, from federal funds. Subcontractor and Participating Providers are therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

4.8 CMS Contract. Subcontractor shall perform the services set forth in the Agreement in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract. Subcontractor shall also require that health care services rendered to MA Customers by Participating Providers pursuant to the Agreement are performed in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract.

4.9 Records.

(a) Privacy and Confidentiality; Customer Access. Subcontractor shall safeguard MA Customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, including the requirements established by MA Organization and the Medicare Advantage program, as applicable. Subcontractor shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law. Subcontractor shall require Participating Providers to comply with all the requirements in this section with respect to records and information related to health care services provided by Participating Providers to MA Customers pursuant to the Agreement.

(b) Retention. Subcontractor shall maintain records and information related to the services provided by Subcontractor under the Agreement including, but not limited to, MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Subcontractor shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all other records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

(c) Government Access to Records. Subcontractor acknowledges and agrees that the U.S. Department of Health and Human Services, the Comptroller General, or their designees shall have the right (directly or through the MA Organization) to audit, evaluate, collect, and inspect any pertinent books, contracts, computer or other electronic systems (including medical records and documentation), and other records and information of Subcontractor and Participating Providers related to the CMS Contract. Subcontractor shall, and shall require Participating Providers to, make available its premises,

physical facilities, and equipment, records relating to MA Customers and any additional relevant information CMS may require. This right shall extend through the longer of the time periods identified in subsection 4.9(b)(i) and (ii), or ten (10) years from date of completion of any audit, whichever is later in time.

(d) MA Organization Access to Records. Subcontractor shall, and shall require Participating Providers to, grant MA Organization or its designees such audit, evaluation, collection and inspection rights identified in subsection 4.9(c) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Subcontractor and Participating Providers reasonable notice of the need for such audit, evaluation, collection, or inspection, and will conduct such audit, evaluation, collection, or inspection at a reasonable time and place. Subcontractor shall, and shall require Participating Providers to, submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for (i) the purpose of CMS audits of risk adjustment data, and (ii) other purposes medical records from providers are used by MA Organization, as specified by CMS.

4.10 Subcontracts. If Subcontractor has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries or any other subcontractors, directly or through another person or entity, to perform any of the services Subcontractor is obligated to perform under the Agreement that are the subject of this Appendix, Subcontractor shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Subcontractor shall provide proof of such to MA Organization upon request. In addition, Subcontractor agrees to oversee and monitor, on an ongoing basis, the services Subcontractor has subcontracted to another person or entity. Subcontractor further agrees to promptly amend its agreements with such subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization, to meet any additional CMS requirements that may apply to the services. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.11 Offshoring. All services provided by Subcontractor pursuant to the Agreement that are subject to this Appendix and that involve MA Customer's protected health information ("PHI") must be performed within the United States, the District of Columbia, or the United States territories unless Subcontractor previously notifies MA Organization in writing and submits required offshoring information to, and receives approval from, MA Organization.

The following provisions apply to Medicare-related services performed pursuant to the Agreement at locations outside of one of the fifty United Sates, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands):

(a) Subcontractor represents and warrants to MA Organization that Subcontractor has in place and will comply with policies and procedures to ensure that all PHI and other personal information remains secure. Subcontractor will provide written evidence of the policies and procedures upon MA Organization's request.

(b) Subcontractor will provide prior written notice to MA Organization of (a) any material change in the Medicare-related services that involve PHI that Subcontractor performs offshore, (b) any material change in Subcontractor's policies and procedures to ensure that all PHI and other personal information remains secure, and (c) any material change in the tools and systems used by Subcontractor to ensure that all PHI and other personal information remains secure.

(c) Subcontractor is prohibited from receiving access to any PHI or other personal information of MA Customers that is not associated with services performed and products provided by Subcontractor pursuant to the Agreement. If Subcontractor receives access to PHI or other personal information of MA Customers that is not associated with Subcontractor's services performed and products provided by Subcontractor pursuant to the Agreement, Subcontractor will immediately notify MA Organization that it has received such access, return all PHI or personal information accessed by

Subcontractor, and destroy any such PHI or personal information that remains in Subcontractor's possession after doing so (i.e. copies, electronic records, back-ups or temporary files).

(d) Subcontractor's services under the Agreement may be terminated immediately upon discovery of a significant security breach.

(e) Subcontractor authorizes MA Organization or its designee to conduct an audit of Subcontractor's offshore activities at least annually.

(f) Subcontractor acknowledges and agrees that MA Organization will use the results of its audit of Subcontractor to evaluate the continuation of MA Organization's relationship with Subcontractor.

(g) Subcontractor authorizes MA Organization or its designee to share the results of audits of Subcontractor with CMS.

SECTION 5
OTHER

5.1 Payment. MA Organization or its designee shall promptly process and pay or deny a Participating Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Subcontractor or Participating Providers are responsible for making payment to subcontracted providers for services provided to MA Customers, Subcontractor shall, and shall require Participating Providers to, promptly process and pay or deny such providers no later than sixty (60) days after Subcontractor or a Participating Provider receives request for payment for those services from subcontracted providers.

5.2 Regulatory Amendment. MA Organization may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, CMS. MA Organization shall provide written or electronic notice to Subcontractor of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Subcontractor will not be required in order for the amendment to take effect.

TENTH AMENDMENT
TO THE BEHAVIORAL HEALTH SERVICES AGREEMENT

This Tenth Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of August 1, 2020 (the "Amendment Effective Date") by and between United Behavioral Health, 425 Market Street, 14th Floor, San Francisco, CA 94105 ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012, as subsequently amended, (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

United Behavioral Health

Signature: DocuSigned by: Matthew J Hedman 87F32863040E440...

Print Name: Matthew J Hedman

Print Title:

UnitedHealthcare of Louisiana, Inc.

Signature: DocuSigned by: Collin S. McQuiddy 54CEE839CA27480...

Print Name: Collin S McQuiddy

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	LA Expansion	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	LA Expansion- South Central	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	Gulf	[redacted]	PMPM	ASO

C&S	Medicaid	LA Expansion- Gulf	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	LA Expansion	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children	Behavioral	Capital	[redacted]	PMPM	ASO

		Foster Care, All Ages Male & Female	Health				
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Newborn, 0-2 Months	Behavioral Health	Capital, South Central, North, Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children	Behavioral	Capital	[redacted]	PMPM	ASO

		Child, 1-20 Years	Health				
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Newborn, 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children	Behavioral	South	[redacted]	PMPM	ASO

		Newborn, 3-11 Months	Health	Central			
C&S	Medicaid	SSI Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
E&I	Commercial	Employee Assistance Program (EAP)	Behavioral Health		[redacted]	PMPM	FULL SERVICE
E&I	Commercial	HMO In Network	Behavioral Health		[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Behavioral Health		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15th) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

ELEVENTH AMENDMENT
TO THE BEHAVIORAL HEALTH SERVICES AGREEMENT

This Eleventh Amendment to the Behavioral Health Services Agreement (this "Amendment"), is entered into as of February 1, 2021 (the "Amendment Effective Date") by and between United Behavioral Health, 425 Market Street, 14th Floor, San Francisco, CA 94105 ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Behavioral Health Services Agreement effective March 1, 2012, as subsequently amended, (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

United Behavioral Health

Signature: DocuSigned by: Matthew J Hedman 87F32663040E440...

Print Name: Matthew J Hedman

Print Title: Vice President

UnitedHealthcare of Louisiana, Inc.

Signature: DocuSigned by: Collin McQuiddy 54CEE839CA27480...

Print Name: Collin S. McQuiddy

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members SBH - Chisholm, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Dual Eligible SBH - Dual Eligible, All Ages	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Other SBH - Other, All Ages	Behavioral Health	Capital, Gulf, North, South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - Chisholm Class Members	Behavioral Health	Capital	[redacted]	PMPM	ASO

		SBH - Chisholm, All Ages Male & Female					
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 20 & Under, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 20 & Under, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Chisholm Class Members	Behavioral Health	North	[redacted]	PMPM	ASO

		Chisholm, All Ages Male & Female					
C&S	Medicaid	Chisholm Class Members Chisholm, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	LA Expansion	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	LA Expansion	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	LA Expansion	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	LA Expansion	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	LaCHIP Affordable Plan All Ages	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Foster Care Children Foster Care, All Ages Male & Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO

C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Newborn, 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SBH - HCBS Waiver SBH - 21+ Years, Male and Female	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Adult, 21+ Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	HCBS Waiver 21+ Years, Male and Female	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 0-2 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Newborn, 0-2 Months	Behavioral Health	Capital, Gulf, North, South Central	[redacted]	PMPM	ASO

C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Breast and Cervical Cancer BCC, All Ages Female	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	SSI Child, 1-20 Years	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Capital	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	Gulf	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	North	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Newborn, 3-11 Months	Behavioral Health	South Central	[redacted]	PMPM	ASO
C&S	Medicaid	Family and Children Child, 1-20 Years	Behavioral Health	Gulf	[redacted]	PMPM	ASO
E&I	Commercial	HMO Plus In Network	Behavioral Health		[redacted]	PMPM	ASO
E&I	Commercial	HMO In Network	Behavioral Health		[redacted]	PMPM	ASO
E&I	Commercial	Employee Assistance Program (EAP)	Behavioral Health		[redacted]	PMPM	FULL SERVICE
M&R	Medicare	Medicare Advantage	Behavioral Health		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15th) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Subcontract") between UnitedHealthcare of Louisiana, Inc. ("United") and subcontractor named in the agreement to which this Appendix is attached (the "Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the State of Louisiana's Healthy Louisiana and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. Subcontractor shall comply with all provisions of this Appendix to the extent applicable to Subcontractor's services under the Subcontract. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Agreement:** An executed contract between Subcontractor and a Provider for the provision of Covered Services to persons enrolled in the State Program(s).

2.2 **Covered Person(s):** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement and/or Subcontract.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or LDH:** The Louisiana Department of Health.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement with Subcontractor for the provision of Covered Services to Covered Persons.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract with LDH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Healthy Louisiana and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services - and that are needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services also include services defined as such under 42 U.S.C. § 1395dd(e) ("anti-dumping provisions").

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Although a service may be deemed medically necessary, it does not mean the service will be covered under the State Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards; Hours of Operation; Appointments. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, including Section 7.2, and as further described in the applicable provider manual.

3.3 Antitrust. Provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any State Program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Healthy Louisiana. For purposes of this assignment clause, "Provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries

3.4 Medicaid or CHIP Participation. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in United's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. United will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals

3.6 Electronic Visit Verification (EVV). Subcontractor must, and shall require Provider to use the state-contracted electronic visit verification (EVV) system in accordance with the timeframes set forth in the 21st Century Cures Act and as directed by LDH.

3.7 Health Records. Provider agrees to cooperate with United to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards

3.8 Overpayments. Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment.

3.9 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 C.F.R. §§ 417.479, 438.3, 422.208, and 422.210 . Neither United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

3.10 Disclosure. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 C.F.R. §§ 455.100-107 and 455.400-470. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 C.F.R. § 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 C.F.R. § 455.434.

Provider shall report to United loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of receipt of notification, if required to be accredited. Provider shall also immediately report cancellation of any required insurance coverage, licensure, or certification to United.

3.11 Cultural Competency and Access. Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired

for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities

3.12 Overpayments. Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment

3.13 Data and Reports. Provider agrees to cooperate with and release to United any information necessary for United to comply with the State Contract and federal and state law, to the extent applicable to Provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters, and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. All reports and data must be provided within the timeframes specified and in a form that meets United and State requirements. By submitting data to United, Provider represents and attest to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.14 Claims Information. Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Provider shall submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

Provider is encouraged, as an alternative to the filing of paper-based claims, to submit and receive claims information through electronic data interchange (EDI).

3.15 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State

and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied. Provider must report loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of recei9pt of notification, if required to be accredited.

3.16 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with United's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.17 Non-Discrimination. Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability

3.18 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

3.19 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

3.20 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

3.21 Advance Directives. Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 489, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.22 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

3.23 Termination. In the event of termination of the Agreement, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims.

3.24 Complaints and Appeals. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with LDH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have a correct and adequate supply of such public notices.

3.25 Health Care-Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to United any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438, and 447.26.

3.26 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH has the right to direct United to impose financial consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

3.27 Clinical Laboratory Improvements Act (CLIA) certification or waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services

performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services

3.28 Hospital Providers. As applicable, Provider must register all births through LEERS (Louisiana Electronic Event Registration System) administered by the LDH/Vital Records Registry. Hospital Providers must notify United and LDH of the birth of a newborn when the mother is a member of United, complete the web-based LDH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to LDH.

3.29 Mental Health and Substance Use Providers. Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable.

3.30 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable State Program approved cost sharing, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services ("HHS") and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR §447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

If the services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. Subcontractor shall, and to the extent applicable to Provider in performance of the Agreement, shall ensure Provider indemnifies, defends, and holds LDH and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Subcontractor or Provider, its agents, officers, employees or contractors arising from the Agreement. LDH may waive this requirement for public entities if Subcontractor or Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time. Subcontractor and Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Subcontractor and Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Subcontractor and Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given

access to and can request copies of the Covered Person's medical records, to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, LDH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Records Access. Subcontractor acknowledges and agrees and shall require Provider to acknowledge and agree that the State, HHS, Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Subcontractor and Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the Subcontractor agrees, and shall require Provider to agree, to not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. Subcontractor and Subcontractor's Provider agrees that this contract creates for the MFCU an enforceable right for which the MFCU can petition the court in the event of non-compliance with an information, records or data request.

Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records to the extent and in the manner provided by La.R.S. § 40:1299.9

(d) Records Retention. As required under State or federal law or the State Contract, Subcontractor shall and shall require Provider to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposal of records must be requested and approved by United if the Agreement is continuous. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

(d) Records Upon Audit. Subcontractor shall require Provider to have online retrieval and access to documents and files for audit and reporting purposes for 10 years in live systems and an additional 4 years in archival systems. Historical encounter data submission shall be retained for a period not less than 10 years, following generally accepted retention guidelines. Services which have a once in a lifetime indicator (i.e., appendix removal, hysterectomy) are denoted on LDH's procedure formulary file, and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID, provider NPI, and/or ICN (internal control number) to include pertinent claims data and claims status. Audit trails shall be maintained online for no less than 6 years. Provider shall provide access to information in machine-readable format within 48 hours of requests for information less than 6 years old and within 72 hours of requests for information greater than 6 years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress or unresolved, information shall be kept in electronic form until all tasks or proceedings are completed. Under no circumstances shall the Provider destroy or dispose of any such records, even after the expiration of the retention periods provided above, without the express prior written permission of LDH

(e) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to LDH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Audit; Investigations.

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor acknowledges and agrees and shall require Provider to acknowledge and agree that all agencies listed above or any of their designees shall be provided with access to all documents and records related to the program services and the right to examine, evaluate and investigate, including on-site audits and examinations and private interviews of Subcontractor's clients and employees. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as

often as they may deem necessary during the State Contract period and for a period of ten (10) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs with no charge to the agencies listed above.

(b) By LDH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of LDH.

(c) Subcontractor shall require Provider to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. Provider agrees that the Agreement creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

(d) Subcontractor shall require Provider to agree that the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Provider, or of the Provider's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under United's contract with the State. Provider will make available, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Covered Persons. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate and audit the subcontractor at any time.

(e) Subcontractor shall require Provider to make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG),

HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require Providers to agree that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 C.F.R. §§ 160.101 et seq., 162.100 et seq., and 164 et seq., as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 C.F.R. §§ 2.1 et seq., 431.300-307, 434.1 et seq., 438.224 and 438.3 (as applicable).

Subcontractor will require that Provider further acknowledge that, in some cases, Provider will have access to information on individuals with whom Provider has no treatment or other relationship. In such cases Provider will abide by all requirements under HIPAA and ensure that the confidentiality of such information is fully maintained.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with the Agreement and Subcontract, including the HHS, the Department and other individuals or entities as may be required. Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA

regulations. Subcontractor shall, and shall require Provider to notify United and LDH of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the LDH with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and LDH to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract, MCO Manual and LDH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract, MCO Manual and LDH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and LDH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the LDH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall require Provider to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor or Provider in their performance of the Subcontract and Agreement. Subcontractor and Provider understand that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Subcontractor's or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor and Provider understand and agree that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Subcontractor shall require Provider to agree that they will provide medical records to United upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR § 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Subcontracts. If Subcontractor or Provider subcontracts or delegates any functions of the Subcontract or Agreement, in accordance with the terms of the Subcontract or Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. Subcontractor and Provider further agree to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

4.11 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR § 93, 100 et seq., as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.12 Excluded Individuals. Subcontractor certifies, and shall require Provider to certify to the best of their knowledge and belief that neither it nor any of its principals, nor any Providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under 42 U.S.C. § 1320a-7; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. United will exclude from its network any provider who has been excluded from the Medicare, Medicaid or CHIP program in any state. United may also terminate the Agreement if Subcontractor or Provider or Subcontractor's or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Subcontract and Agreement must be submitted to United to submit to the Department for prior approval..

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist LDH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network, employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA), Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the False Claims Act (established under sections 31 U.S.C. §§ 3729 - 3733), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 C.F.R. § 438.600; (b) cite administrative remedies for false claims and statements established by 31 U.S.C. § 3801 et seq and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)), include as part of such written policies, detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.16 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in LDH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information. Provider is encouraged to adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC). If Provider is an emergency departments (EDs), Provider agrees and is required to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry would consist of three basic attributes: (a) the ability to capture and match patients based on demographics information, (b) the ability to identify the facility at which care is being sought, and (c) at minimum, the chief complaint of the visit. These three pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country.

4.17 Insurance Requirements. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. LDH

and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider. Subcontractor shall and shall require that Provider immediately report cancellation of any required insurance coverage, licensure, or certification to United.

4.18 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.19 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United. If Subcontractor or Provider receives consent, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Subcontractor and/or Provider as applicable agree to promptly amend agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

4.20 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.21 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.22 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or LDH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

If Provider discovers an error or a conflict with a previously adjudicated encounter claim, Subcontractor and/or Health Plan shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or if circumstances exist that prevent

Subcontractor and/or Health Plan from meeting this time frame a specified date shall be approved by LDH.

When Subcontractor has entered into an alternative reimbursement arrangement with Provider, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the Subcontractor.

4.23 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.24 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by LDH.

4.25 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the amount, duration, and scope of benefits and services of Subcontractor's and/or Provider's practice.

4.26 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.27 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall require Provider to agree to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Subcontract and Agreement. Subcontractor understands, and shall require Provider to agree that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor and Provider stipulate that Louisiana law, without regard to its conflict of laws provision, will prevail if there is a conflict between the state law where the material contractor is based and Louisiana law. Subcontractor shall require that Provider agrees that Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.28 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

4.29 Healthcare Oversight Agency Compliance. Subcontractor shall, and shall require Providers to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities that manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but do not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and United, Subcontractor or Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. United, Subcontractor and/or Provider agree that the State Contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

SECTION 5
UNITED REQUIREMENTS

5.1 Prompt Payment. United shall pay Subcontractor pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the State Contract.

If LDH discovers an error or a conflict with a previously adjudicated encounter claim, United will adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH.

5.2 No Incentives to Limit Medically Necessary Services. United shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not

interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

5.4 Communication with Covered Persons. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Subcontract shall be performed in accordance with the requirements of the State Contract and LDH issued guides, the applicable provisions of which are incorporated into the Subcontract by reference. Nothing in the Subcontract relieves United of its responsibility under the State Contract. If any requirement or provision of the Subcontract or this Appendix is determined by LDH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Subcontract or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Subcontract and this Appendix shall remain in full force and effect.

6.2 Monitoring. United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Subcontract and shall perform periodic formal

reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or LDH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established under the State Contract.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of LDH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and LDH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that LDH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the

State Contract. United will submit and obtain prior approval from LDH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of LDH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.10 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by LDH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

In addition, United agrees to comply with the claims processing requirements in the State Contract. At a minimum, United shall run 1 provider payment cycle per week, on the same day each week, as determined by United. United shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments. United shall encourage that its providers submit and receive claims information through electronic data interchange (EDI) as an alternative to the filing of paper-based claims. Claims shall be processed in adherence to information exchange and data management requirements specified in the State Contract. United shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud, abuse, or waste or otherwise included on the Department of Health and Human

Services Office of Inspector General exclusions list, or employs someone on this list. United shall not pay any claim submitted by a provider that is on payment suspension and/or withhold under the authority of LDH or its authorized agent(s). United shall inform all network providers about Clean Claim requirements. United shall make requirements and guidelines for claims coding and processing that are specific to Provider types available to network providers. United shall notify providers 90 calendar days before implementing changes to claims coding and processing guidelines, or as soon as possible if directed by LDH pursuant to state or federal law to implement such change earlier.

6.11 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.12 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.13 Enrollment. The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Exclusivity. Nothing in the Subcontract or this Appendix shall be construed as prohibiting or penalizing Subcontractor for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other subcontractors or providers.

6.16 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.17 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

Exhibit B: Material Subcontractor Response Template

Proposer (MCO) name:
UnitedHealthcare of Louisiana, Inc.
Material subcontractor name:
Dental Benefit Providers, Inc. (DBP)
Description of the Proposer's role and material subcontractor's role:
Proposer's Role: To provide high quality health care services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program, while using the most cost-effective manner and in accordance with LDH's terms and conditions. **Material Subcontractor's Role:** To provide dental benefit management services, provider network development and maintenance, provider credentialing and re-credentialing, utilization review and management, fraud waste and abuse management, ongoing account management, provider services (i.e., call center, issue resolution), claim services (i.e., receipt, entry, adjudication), regulatory reporting, third party administration, audit support and encounter reporting.
Explanation of why the Proposer plans to subcontract this service and/or function:
To support UnitedHealthcare of Louisiana in its mission of providing high quality dental benefit management services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program, utilizing the most cost-effective manner and in accordance with LDH's terms and conditions. **For example, to best serve Louisiana enrollees and to meet LDH's goals, DBP will:** • **Ensure enrollees ready access to care** by expanding access for all enrollees, encouraging enrollees to use their benefits, and increasing utilization of preventive and diagnostic, minor restorative and oral surgery services in combination with healthy behaviors at home. Clinical evidence increasingly shows links between poor oral health and chronic medical conditions, such as diabetes, heart disease and pregnancy complications. The intended result is to reduce enrollee risks for dental disease—in oral and overall health—while reducing dental and medical costs (e.g., costs of managing dental and chronic medical disease, such as diabetes, and ER utilization and hospitalization). • **Minimize wasteful spending, abuse, and fraud** through our peer comparison reporting (PCR), in which we identify providers with aberrant utilization patterns, flagging them when a category or code utilization is twice the network average or more. This tool generates real-time provider profiles for providers identified as outliers and compares their utilization to peers (same geography, same specialty). Providers identified via analytics are then reviewed clinically by our staff dentists to confirm outlier trends.
A description of the material subcontractor's organizational experience:

Dental Benefit Providers, Inc. (DBP)

Founded in 1984, Dental Benefit Providers, Inc. has more than 37 years of experience managing commercial, Medicaid, Medicare Advantage and individual dental programs across the United States, which serves more than 15 million enrollees nationwide through a network of more than 400,000 dentist access points. DBP's clients include employer groups, individuals, health plans, state and local government organizations, insurance companies and TPAs. In June 1999, UnitedHealth Group Incorporated became a majority owner of DBP and in September 2002, DBP became its wholly owned subsidiary. DBP continues to function as the legal and administrative entity, which provides dental administration to UnitedHealthcare of Louisiana, Inc.

In Louisiana, they provide dental programs for UnitedHealthcare for all market segments including, commercial, Medicaid, Medicare Advantage and individual, covering more than 318,000 Louisiana enrollees. DBP's Louisiana dental network has 4,935 dental access points statewide.

For public sector experience, DBP has extensive experience serving all populations within the Medicare Advantage and Medicaid markets, including children, adults, and seniors, and those with special needs and in long-term care. Currently, they manage Medicare Advantage programs in 49 states and Medicaid programs in 16 states, including Louisiana, serving a combined population of more than 8.1million Medicaid and Medicare Advantage enrollees.

Since 2015, DBP has provided dental services for Healthy Louisiana recipients; currently, their Louisiana Adult Value Add dental network has 952 dental access points, and it serves more than 235,000 Louisiana enrollees, meeting the needs of the Louisiana Medicaid population.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

We monitor and manage the performance of subcontractors through the mechanisms described below. These mechanisms facilitate our oversight of the subcontractors and allow us to evaluate performance, especially with respect to state contractual requirements. Unless otherwise noted, we use these approaches for our affiliate entities within UnitedHealth Group and nonaffiliate subcontractors:

- ***Operating Arrangements:*** The operating document incorporates a description of the required functions and service levels, the process by which we assess performance, the recourse we have if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate), and the authority of Karl Lirette and the executive team to drive change. Relationships are constructed, formalized, and managed with the consent of LDH, the subcontractor and UnitedHealthcare. LDH has the right to review and approve or disapprove all subcontracts for the services provided under this contract.
- ***Vendor Collaboration Meeting:*** As appropriate, we invite representatives from our subcontractors to our regular operations meetings, promoting understanding of how each functional area is dependent upon the success of the others. During these meetings, we provide direction for our subcontractors and verify their quality and effectiveness is sufficient to meet objectives. Local functional area business owners also report on subcontractor performance and measurements. Operations meetings include:
    - Feedback and oversight
    - Review of policies and procedures

- Training and education
- Monitoring of key performance indicators
- Effective lines of communication
- Responding to issues/escalating when necessary

- ***Joint Operating Committee (JOC):*** Our Joint Operating Committee monitors subcontractor performance during regularly scheduled meetings. An expedited meeting may be called to address critical issues in a timely manner as determined by our leadership and our subcontractor(s). The scope of the JOC includes developing compliance strategies and initiatives to support the subcontractor's performance such as:
  - Overall review of business performance
  - Assessment of key compliance/regulatory issues and risks
  - Audit planning and reporting
  - Escalation of issues, especially from local health plans
  - Review of fraud, waste, and abuse prevention efforts
  - Confirmation of monthly checks of federal and state exclusion lists
  - Response to identified issues

Membership of the JOC includes Louisiana plan leadership, national representatives and key business leads from UnitedHealthcare's Community & State (Medicaid) organization, and operational partners.

- ***Dedicated Staff:*** We designate accountable relationship owners from the Louisiana health plan in the appropriate functional area to work with specific subcontractors. The local relationship owner works with regional and national relationship owners to perform this oversight. Subcontractors may require additional attention when their responsibilities are of a critical nature or where performance warrants additional oversight. We understand that such steps are necessary for high quality, given the size of our health plan and the large number of members and providers that depend on us. These staff members monitor and drive improvement in our subcontracted services.
- ***Statistics and Reports:*** Subcontractors are required to report key performance indicators on a monthly or basis. These reports allow UnitedHealthcare staff to monitor and evaluate subcontractors, as well as indicate action steps for improvements. Review of these statistics occurs in monthly and quarterly committee reviews.
- ***Collaboration Calls:*** During monthly or as appropriate collaboration calls, our CEO, COO and CMO (as needed), members of the local team meet with executives from our affiliate organizations, allowing for constant exchange of best practices, problem-solving and innovations that are working in other markets. Executives from our claim's operations, member and provider services centers, provider contracting, pharmacy and other functional areas attend this meeting as needed. In addition, this dialogue allows our executive staff to provide direct feedback to our partners on their service quality and reinforce the prioritization of our Medicaid programs to promote contract compliance. UnitedHealthcare uses these overall monitoring approaches and mechanisms to identify and prioritize areas for improvement, set quantifiable goals and metrics, and communicate clear expectations. By creating a systematic approach to evaluate and improve our operations with our subcontractors, we have a process that promotes ongoing identification and remediation of operational challenges and implementation of best practices and innovations.
- ***Annual Review:*** We will conduct an annual review of the subcontractor's performance. This review will include, at a minimum, any performance concerns identified by LDH. We will

provide LDH with a copy of the review and any corrective action plans developed as a result.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Regulatory Appendix Pg. 13 Section 4.7
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Base Agreement Pg. 17-17a Second Amendment Pg. 3-4
3	Specify the effective dates of the subcontract agreement. ***NOTE: The Second Amendment added Medicaid to the Base Agreement.***	Second Amendment Preamble Pg. 1 Base Agreement Pg. 10 Section 7
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Regulatory Appendix Pg. 22 Section 6.3
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Regulatory Appendix Pg. 22 Section 6.3
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Regulatory Appendix Pg. 22 Section 6.3
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Regulatory Appendix Pg. 10 Section 4.4(e)
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Regulatory Appendix Pg. 23 Section 6.7
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Regulatory Appendix Pg. 23 Section 6.1

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Regulatory Appendix Pg. 1 Section 2.2
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Regulatory Appendix Pg. 18 Section 4.20
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Regulatory Appendix Pg. 5 Section 3.15
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Regulatory Appendix Pg. 19 Section 4.26
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Regulatory Appendix Pg. 2 Section 3.1(b)
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Regulatory Appendix Pg. 20 Section 4.31
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Regulatory Appendix Pg. 9 Section 4.4(a)
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Regulatory Appendix Pg. 10 Section 4.4 (d)

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Regulatory Appendix Pg. 12 Section 4.5 (e)
19	INTENTIONALLY LEFT BLANK	
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Regulatory Appendix Pg. 5 Section 3.15
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Regulatory Appendix Pg. 22 Section 6.2
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Regulatory Appendix Pg. 22 Section 6.2
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Regulatory Appendix Pg. 8 Section 3.26
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Regulatory Appendix Pg. 18 Section 4.23

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Regulatory Appendix Pg. 13 Section 4.6
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Regulatory Appendix Pg. 23 Section 6.10 Amendment 7 Pg. 3 Section 1
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Regulatory Appendix Pg. 23 Section 6.10
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Regulatory Appendix Pg. 18 Section 4.23
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Regulatory Appendix Pg. 18 Section 4.23
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Regulatory Appendix Pg. 8 Section 4.1
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Regulatory Appendix Pg. 8 Section 4.2

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Regulatory Appendix Pg. 17 Section 4.18
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Regulatory Appendix Pg. 19 Section 4.28
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Regulatory Appendix Pg. 22 Section 6.3
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Regulatory Appendix Pg. 23 Section 6.8
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Regulatory Appendix Pg. 19 Section 4.27
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Regulatory Appendix Pg. 5 Section 3.15
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Regulatory Appendix Pg. 19 Section 4.24
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Regulatory Appendix Pg. 16 Section 4.13

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Regulatory Appendix Pg. 25 Section 6.14
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Regulatory Appendix Pg. 19 Section 4.23
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Regulatory Appendix Pg. 19 Section 4.29
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Regulatory Appendix Pg. 3 Section 3.3

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Regulatory Appendix Pg. 11 Section 4.5(c)

DENTAL SERVICES AGREEMENT

This Dental Services Agreement (this "Agreement"), is made as of January 1, 2014 (the "Effective Date"), by and between Dental Benefit Providers, Inc. ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United"). For services provided on or after its Effective Date, this Agreement supersedes and replaces any and all other agreements, whether written or oral, between the parties regarding the subject matter contained herein.

WHEREAS, United issues and/or administers Benefit Plans on behalf of itself and Payors for the benefit of Members;

WHEREAS, United desires to contract with Vendor for the provision of its services; and

WHEREAS, this Agreement describes the obligations of both of the parties related to the performance of the services.

NOW THEREFORE, in consideration of the terms and conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree as follows:

SECTION 1
DEFINITIONS

The following terms shall have the meanings set forth below. Additional definitions may be set forth in the Agreement or the exhibits.

1.1 "Benefit Plan" shall mean a certificate of coverage, summary plan description, benefit plan, benefit package description or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payor is obligated to provide Member with coverage for Covered Services.

1.2 **"**CMS" shall mean The Centers for Medicare and Medicaid Services.

1.3 "Covered Services" shall mean a health care service or product for which a Member is entitled to receive coverage from a Payor, pursuant to the terms of the Member's Benefit Plan. The type of Covered Services to be provided by Vendor are specified in more detail in an Exhibit B.

1.4 "Member" shall mean a person eligible and enrolled with United to receive coverage from a Payor for Covered Services.

1.5 "Participating Provider" shall mean a licensed or otherwise appropriately qualified and credentialed health care professional or entity that has entered into a Provider Agreement with Vendor, directly or through another entity, to provide Covered Services to Members.

1.6 "Payor" shall mean United or such other entity obligated to provide reimbursement for Covered Services for the Member.

1.7 **"**Provider Agreement" shall mean an agreement between Vendor and a Participating Provider that sets forth the terms and conditions under which the Participating Provider participates in one or more of Vendor's network(s) of providers.

1.8 "Service Area" shall mean the geographic area in which United is authorized to provide Covered Services to Members.

1.9 "Services Addendum" shall mean a description of the services to be provided by Vendor attached to this Agreement as an Exhibit B. The parties may add additional Exhibits for additional services as agreed upon by the parties from time to time. Each such Exhibit shall be numbered as a series of Exhibit B (such as B1, B2, B3 and thereafter).

SECTION 2
SERVICES

2.1 Services Addendum. Vendor shall provide the services described in the Services Addendum to this Agreement.

2.2 United Control and Oversight. Vendor shall be subject to the reasonable direction of United, as it pertains to the services provided pursuant to this Agreement. United shall maintain oversight of Vendor for functions Vendor provides to, or arranges for, United, and will monitor services for quality assurance in conformity with applicable state law and other regulatory requirements as set forth in a regulatory appendix. The parties shall cooperate with and assist each other as reasonably necessary or appropriate in the performance of this Agreement.

SECTION 3
RESPONSIBILITIES AND RELATED PROVISIONS

3.1 Member Eligibility Information. At least monthly, on a date mutually acceptable to United and Vendor, United shall provide Vendor with a current list of eligible Members in an electronic format mutually agreeable to both parties. The eligibility information shall be prepared and provided to Vendor at United's expense. Vendor shall treat the information received under this Section as confidential and not distribute or furnish such information to any other person or entity, except as necessary and as permitted by law to provide or arrange for Covered Services. If United is unable to provide Vendor with a current list of eligible Members in an electronic format, the parties agree to adjust the compensation payable to Vendor pursuant to Section 11.15 should such alternative process cause Vendor to incur material additional costs.

Subject to retroactive eligibility changes that may be required by a state or CMS, Vendor shall be entitled to rely on the most current eligibility information and Benefit Plan documents in its possession in providing the Covered Services, including processing claims for Covered Services, if applicable.

3.2 Retroactive Adjustments of Eligibility. Vendor acknowledges that there may be retroactive adjustments to Member eligibility. United shall use its best efforts to minimize such adjustments.

3.3 Benefit Plans. This Agreement is not intended nor shall be deemed or construed to modify the obligations of United or a Payor to Members as established under any Benefit Plan. United acknowledges that it retains the ultimate responsibility to assure delivery of all benefits required under a Benefit Plan between United and a Member.

3.4 Services Under This Agreement. The responsibilities of Vendor shall be limited as defined by the terms of this Agreement. If Vendor provides or arranges for requested additional services, United or Payor shall pay for the additional services according to Vendor's fee schedule and/or the amounts payable to Participating Providers for such services.

3.5 Responsibility for Information. United understands and agrees that Vendor is not responsible for any delay in the performance of this Agreement or for any non-performance under this Agreement if the delay or non-performance is caused or materially contributed to by United's failure to furnish any material information described in this Agreement.

3.6 New Benefit Plans and Changes to Services. United shall use commercially reasonable efforts to notify Vendor in writing at least ninety (90) days prior to any modification of an existing Benefit Plan, development of a new Benefit Plan or expansion of its Service Area. If such modification, development or expansion is a material change to Vendor's obligations under this Agreement or the pricing assumptions used in establishing rates, the parties shall negotiate to include the modification, development or expansion in this Agreement in accordance with Section 11.15.

3.7 Member Consents and/or Authorizations. United agrees to assist Vendor in obtaining any necessary Member consents or authorizations as required under state or federal law so that Vendor can receive protected health information when necessary for Vendor to perform its obligations under this Agreement.

3.8 Communication Materials and Activities. United and Vendor shall cooperate to provide and prepare Members' publications and programs regarding Covered Services available to Members, as applicable.

United shall use its best efforts to include legally required notices regarding Covered Services or other legally required communications related to Vendor in its scheduled mailings at no cost to Vendor. If United is unable to include legally required communications in its scheduled mailing,

Vendor will reimburse United for actual mailing costs, not to include personnel and other internal expenses.

United shall submit communication materials to state and federal regulatory agencies for prior approval as may be required by and in accordance with applicable state and federal law and regulations.

3.9 Taxes. All fees charged by Vendor for the services provided under this Agreement are exclusive of all taxes and fees (including but not limited to, sales, use, excise, value-added, goods and services, consumption, and other similar taxes, duties or fees) now in force or enacted in the future, imposed on the transaction or performance of the services, all of which United will be responsible for and will pay in full, except for taxes based on Vendor's income (gross or net). Should any payment for Services provided by Vendor be subject to withholding tax by any state or local taxing jurisdiction, United shall reimburse Vendor for such withholding tax.

3.10 Identification Cards. United shall ensure that Members receive an identification card and that a mutually agreeable process is established for referring Members to Vendor when appropriate.

3.11 Non-Interference with Advice to Members. Nothing in this Agreement is intended to prohibit or restrict Participating Providers or other health care professionals from advising or advocating on behalf of a Member about:

(a) the Member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the Member to provide an opportunity to decide among all relevant treatment options;

(b) the risks, benefits and consequences of treatment or non-treatment; and

(c) the opportunity for the Member to refuse treatment and express preferences about future treatment decisions.

SECTION 4
PAYMENT; PAYMENT TERMS

4.1 Fee. For the services, United shall pay Vendor as set forth in each Exhibit A. To the extent that any settlement terms contained in this Agreement may not be specific enough to satisfy SSAP No. 25, the parties agree settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known.

4.2 No Incentive Payments. Vendor shall be strictly prohibited from receiving any incentive payment designed to reduce amounts of necessary medical care through (a) reduction of services

or the charges thereof, (b) reduction of length of stay, or (c) utilization of alternative treatment settings.

4.3 Member Protection. Vendor and United agree that in no event, including, but not limited to (a) non-payment for Covered Services provided to Members; (b) insolvency of Vendor, United or another Payor; or (c) breach by United or Vendor of any term or condition of this Agreement or any term or condition of a Provider Agreement, shall United or Vendor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for Covered Services eligible for reimbursement under the Member's Benefit Plan.

The provisions of this Section shall: (i) be construed in favor of the Member; (ii) survive the termination of this Agreement regardless of the reason for termination; and (iii) supersede any oral or written agreement, existing or subsequently entered into, between any of the parties to this Agreement or a Participating Provider and a Member or the representative of the Member if such agreement is inconsistent with this Section.

This Section shall not prohibit collection of any allowed amounts that are the Member's responsibility to pay for Covered Services to a Participating Provider in accordance with the applicable Benefit Plan. It also shall not prohibit the collection of charges for services that are not Covered Services as defined in the Benefit Plan; provided, however, that the Member has been informed of the costs for non-covered services prior to the rendering of such services and has agreed in writing to accept responsibility for payment for such services. The Member's written consent shall be in a form agreed to by the parties and in compliance with any applicable state and federal law. This provision also shall not prohibit payment for any Covered Services delivered after expiration of benefits under the relevant Benefit Plan. If requested by United, Vendor shall submit to United any Member's written acknowledgement to accept responsibility for non-Covered Services provided to him/her. Vendor shall ensure that Vendor's Provider Agreements with Participating Providers are consistent with the obligations in this Section.

This Section applies when any applicable statutes and regulations require that the Member be held harmless from any and all costs, which are the legal obligation of Vendor, United or another Payor.

SECTION 5
INFORMATION; AUDITS; BOOKS AND RECORDS

5.1 Maintaining Records. The books, accounts and records of each party shall be so maintained as to clearly and accurately disclose the transactions contemplated by this Agreement, including such accounting information as is necessary to calculate and support the amount of the payments made by United under this Agreement. All books, accounts and records shall be maintained in compliance with the applicable laws and regulations of the state in which United is domiciled and in accordance with prudent standards of insurance record keeping. Vendor shall maintain at its principal administrative office, and shall require, as applicable, Participating

Providers and any subcontractors to maintain, adequate books and records of all transactions related to the services provided pursuant to this Agreement. Vendor shall maintain such books and records for ten (10) years after the date the records were created unless a different retention period is specified by applicable law or regulation, then such records shall be preserved for such period as required by applicable law or regulation.

5.2 Member Access to Records. Vendor shall, and shall require its Participating Providers to, establish and maintain procedures in accordance with applicable law and regulations to ensure, at a minimum, timely access by Members to medical records and other health information in their possession that pertains to Members.

5.3 Examination of Books and Records. Upon reasonable notice, during normal business hours and at a reasonable time and place, United or its designee shall have the right to examine any books or records of Vendor that relate to this Agreement during the term of this Agreement and for three (3) years thereafter unless otherwise required by law.

5.4 Corrective Action Plans. United shall provide Vendor with a report of any audit findings resulting from an examination within thirty (30) calendar days of the conclusion of an audit. If United notes a regulatory deficiency(ies) during the audit or otherwise notes a failure or delay in performance by Vendor, United may request Vendor to develop a corrective action plan. Upon such a request, Vendor shall prepare a corrective action plan and provide it to United for United's approval within thirty (30) calendar days of United's request. Such plan shall (a) be subject to United's approval (which shall not be unreasonably withheld); and (b) include specifics of and timelines for correcting the regulatory deficiency(ies) (which shall not exceed thirty (30) days).

United shall approve or disapprove the initial corrective action plan in a reasonable timeframe after receipt of such plan from Vendor. Vendor shall implement the approved corrective action plan within the timeframes specified therein. If the corrective action plan is not satisfactory to United or implemented to the reasonable satisfaction of United, United may terminate this Agreement pursuant to Section 7.1.

5.5 Government and Accrediting Agency Access to Records. Government and accrediting agencies which license the operation of United or Vendor shall have the right to inspect, evaluate and audit applicable records. United and Vendor are hereby authorized to release all information and records or copies of such within the possession of United or Vendor that are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to United or Vendor. These audit and inspection rights shall exist for three (3) years from the termination date of this Agreement, the date of completion of any audit, or such other period as required by law or as may be set forth in an Appendix.

5.6 Confidential Information. The parties acknowledge that in the course of performing their obligations under this Agreement, either party may learn or receive confidential and proprietary information, including, but not limited to, trade secrets, business or organizational plans,

customer lists, pricing, and underwriting information, concerning the other party or third parties to whom the other party has an obligation of confidentiality (collectively "Confidential Information"). Confidential Information shall not include information that:

(a) was rightfully in the party's possession prior to receiving Confidential Information;

(b) is currently or subsequently becomes available to the public through a source other than the receiving party;

(c) the party develops internally, without reference to the other party's Confidential Information; or

(d) the party receives from a third party on a non-confidential basis from a source, which to the best of such party's knowledge after due inquiry, is not prohibited from discussing such information by a legal, contractual or fiduciary obligation.

Each party shall take all necessary steps to provide the maximum protection to secure the other party's Confidential Information. Each party agrees to take at least such precautions to protect the other party's Confidential Information as it takes to protect its own Confidential Information. The parties shall not utilize any Confidential Information belonging to the other party without the other party's prior written consent for any purpose other than performance under this Agreement. The parties agree not to disclose Confidential Information to third parties without the express prior written consent of the party to whom the information belongs. The parties further agree that they will not disclose Confidential Information to anyone within their respective organizations other than those employees with a need to know and who have been informed of the party's obligations under this Agreement. The parties may disclose Confidential Information to their attorneys, accountants, or other agents ("Representatives"), but only if they need to know the Confidential Information as described above. The parties shall inform each Representative of the confidential and proprietary nature of the Confidential Information. Upon termination of this Agreement, a party in possession of any Confidential Information belonging to the other party shall either return such Confidential Information to the other party or destroy the Confidential Information, without retaining copies. If any Confidential Information is impossible or impracticable to return or destroy, the party holding such other party's Confidential Information shall remain bound by the terms of this section with regards to the applicable Confidential Information. Each party shall retain sole ownership of its own Confidential Information.

5.7 Required Disclosures. The confidentiality obligations described herein will not restrict any disclosure required by order of a court or any government agency. The party being ordered to disclose the information shall give prompt notice to the other party of any such order and reasonably cooperate with the other party, at the other party's request and expense, to resist such order or to obtain a protective order.

5.8 Ownership; Communications**.** Except as otherwise expressly provided for in this Agreement:

(a) Any books and records provided by United to Vendor pursuant to this Agreement, or developed or maintained by United under or related to this Agreement, shall be owned by United and are subject to the control of United.

(b) All funds and assets of Vendor are the property of Vendor, held for the benefit of Vendor and are subject to the control of Vendor.

(c) All funds and assets of United are the property of United, held for the benefit of United and are subject to the control of United; provided that United agrees to grant Vendor and its affiliates access to United's assets as necessary to perform the duties under this Agreement; or as may reasonably assist Vendor and its affiliates to perform hereunder, including without limitation to assist Vendor, in concert with other affiliated health plans, to achieve cost efficiencies on United's behalf; or as otherwise permitted by United and by applicable law. Neither this Agreement nor the performance of duties pursuant to this Agreement shall grant Vendor or its affiliates any ownership interest in United's assets used by Vendor or its affiliates pursuant to this Agreement.

(d) Each party shall retain all right, title and interest in its proprietary business information or work product that may be used in advertising or promoting Covered Services or that is related to other activities under this Agreement, including, but not limited to, trade secrets, computer software and applications, and any other proprietary business information or work product that is not available to the general public.

(e) Upon termination of this Agreement, each party will return to the other party all intellectual property and work product belonging to the other party and shall not retain copies of such data except as shall be necessary under applicable law.

Except as authorized in this Agreement, each party further agrees to obtain the other party's permission before using any of the other party's copyrighted materials in its communications materials. If either party produces its own communications materials, it shall do so at its own cost and submit materials that use the other party's trademarks, logos, copyrighted or other branding materials to describe Covered Services to the other party for prior review and approval, which shall not be unreasonably withheld or delayed. Any promotional videos may be rebroadcast and brochures made available via the parties' intranet solely for the purpose of providing information about Covered Services to Members; provided, however, such materials contain an appropriate copyright acknowledgment. Neither party shall reproduce any marketing, advertising, or promotional materials, including but not limited to, videos, brochures, posters, newsletters and any other copyrighted materials without the other party's prior written consent, unless expressly permitted otherwise under this Agreement.

SECTION 6
REGULATORY COMPLIANCE

6.1 Compliance with Laws, Regulations; Licensure. Vendor shall maintain and shall, as applicable, require all Participating Providers and health care professionals employed by or under contract with Vendor, to maintain all federal, state and local licenses, certifications, permits, regulatory approvals and accreditations, without material restriction, that are required to provide the services under this Agreement. Vendor and United shall comply (and, as applicable, Vendor shall require Participating Providers and health care professionals employed by or under contract with Vendor to comply) with all laws and regulations applicable to the services provided hereunder, including without limitation the regulatory provisions set forth in individual appendices attached to this Agreement and made a part hereof (the "Appendix(ces)"), which provisions are hereby incorporated into and made a part of this Agreement. United may add, delete or replace Appendices from time to time as necessary to comply with applicable law without amending this Agreement. Services rendered under this Agreement shall be subject only to those provisions in any Appendix that by law or regulation are applicable to such category of services. Vendor shall comply with the applicable terms and conditions of such Appendices.

Vendor shall notify United if a governmental authority notifies Vendor that it must be licensed as an insurer, health service plan, health maintenance organization, prepaid limited health services organization, or other type of licensed insurer to provide services. In such event, Vendor may cease providing the services that would subject Vendor to such licensure, unless Vendor and United can agree upon an amendment to this Agreement that would make such licensure unnecessary. Any such cessation of services shall be effective the earlier of the date required by the governmental authority or after at least sixty (60) days following prior written notice to United.

6.2 Protected Data. The parties acknowledge and agree that, in the course of performing hereunder, Vendor will receive on behalf of United personal data identifying individuals covered by United, protected health information, and other data protected by law. With respect to such data, Vendor and United shall comply with the Health Insurance Portability and Accountability Act of 1996, the Gramm-Leach Bliley Act, and all other applicable confidentiality, privacy and data security laws and regulations.

6.3 Regulatory Approval and Filing. United shall be responsible for filing this Agreement with any governmental authorities as may be required by any applicable law or regulation. If the governmental authority requests changes to this Agreement, Vendor and United shall jointly discuss the response to the governmental authority. If any governmental authority requires a change to this Agreement that either Vendor or United deems to be material, either party may request re-negotiation of the affected provisions of this Agreement pursuant to Section 11.15.

6.4 Delegation of Activities; Oversight. To the extent applicable to any Covered Services, in compliance with the delegation and oversight obligations imposed on United, including by the applicable state or under its contracts with any state and/or federal regulatory agencies, United

(a) shall conduct at least an annual audit of Vendor's performance of such delegated activities and (b) has the right (including if asked by a regulatory agency) to revoke any functions or activities delegated to Vendor under this Agreement, if in United's reasonable judgment, Vendor's performance under this Agreement does not comply with United's obligations. This right shall be in addition to United's termination rights under this Agreement.

6.5 Immunity. Vendor and United agree that activities delegated to Vendor by United may be considered professional and quality review procedures and that both Vendor and United may be immune pursuant to the Health Care Quality Improvement Act (42 U.S.C. 11101, et seq., as may be amended from time to time), or other state or federal law, from any civil liability arising from the delegated activities. Vendor agrees to maintain the confidentiality of any privileged information to the extent permitted by law and obtain United's prior written consent before disclosing privileged information to any third party, except as may otherwise required by law.

SECTION 7
TERM; TERMINATION

7.1 Term and Termination. This Agreement shall commence on the Effective Date and shall continue until terminated as follows:

(a) by mutual agreement of the parties;

(b) by either party upon at least 60 days prior written notice to the other party;

(c) by either party, upon at least 30 days prior written notice to the other party in the event of a material breach of this Agreement by the other party unless the material breach has been cured or a reasonable corrective action plan has been developed and approved by the other party before the end of the notice period;

(d) by either party, immediately upon written notice to the other party, in the event of the other party's loss or suspension of material licensure, certification or other governmental authorization necessary to perform under this Agreement;

(e) immediately if required by a state or federal regulatory agency with jurisdiction over this Agreement.

In the event this Agreement is terminated, United shall provide notice thereof in accordance with all requirements of the insurance laws of the state in which United is domiciled.

Upon notice of termination of this Agreement given by one party to another, United shall pay all fees owed to Vendor pursuant to the payment terms under this Agreement and Vendor shall provide services until the effective date of the termination except as provided under Section 7.5 or otherwise required by law.

7.2 United Receivership. If United is placed in receivership pursuant to the relevant state receivership act:

(a) Vendor shall have no automatic right to terminate this Agreement;

(b) Vendor shall continue to maintain any systems, programs or other infrastructure notwithstanding such receivership and will make them available to the receiver for as long as Vendor continues to receive timely payment for services rendered;

(c) all of the rights of United under this Agreement shall extend to the receiver; and

(d) United's books and records shall immediately be made available to the receiver and shall be turned over to the receiver immediately upon the receiver's request.

7.3 Effect of Expiration or Termination. Upon the expiration or termination of this Agreement, Vendor will cooperate with United and/or United's designee to transition the care and management of Members undergoing treatment on the date of expiration or termination. Vendor, United and/or United's designee will work together to transition business, medical, and management records to United or United's designee in a commercially reasonable manner that reflects the rights and obligations of all parties, including Vendor's need for ongoing access to such records.

7.4 Notice to Members. Upon notice of termination of this Agreement, United and/or Payor shall have the right to notify, at their own expense, Members of such termination.

7.5 Continued Provision of Covered Services After Termination. Vendor agrees that in the event this Agreement is terminated, Vendor shall use commercially reasonable efforts to cause Participating Providers to continue to provide Covered Services to any Members undergoing treatment at the time of such termination until the earlier of:

(a) the current episode of treatment is completed, or as to any Members confined in inpatient facilities on the date of such termination, until such Members are discharged; or

(b) arrangements are completed for such Members to be transferred to another provider.

Participating Providers shall be reimbursed in accordance with their Provider Agreements for all such services rendered subsequent to the termination of this Agreement.

SECTION 8
INSURANCE

Unless otherwise agreed to by the parties in writing, Vendor shall procure and maintain the insurance or self-insurance programs in the minimum amounts set forth below. Any such self-

insurance programs will include actuarially approved funding levels. Vendor will provide United evidence of such insurance upon request.

(a) Commercial general liability insurance coverage, including but not limited to errors and omissions, in the minimum amounts of one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate for the policy year.

(b) Professional liability insurance coverage in the minimum amounts of ten million dollars ($10,000,000) per occurrence and ten million dollars ($10,000,000) aggregate for the policy year.

(c) As applicable, worker's compensation insurance coverage for Vendor employees in an amount and form meeting all applicable legal requirements.

SECTION 9
INDEMNIFICATION

The parties shall each indemnify and hold the other harmless from and against any and all liabilities, including but not limited to, losses, penalties, fines, costs, damages, claims, causes of action, and expenses the other incurs, including reasonable attorneys' fees, to the extent caused by the indemnifying party's (a) material breach of this Agreement; or (b) willful misconduct or reckless or grossly negligent act or omission related to or in connection with performance under this Agreement.

SECTION 10
DISPUTE RESOLUTION

The parties shall attempt in good faith to resolve any disputes arising from this Agreement ("Disputes") in the normal course of business at the operational level.

Either party may elect to submit any Disputes that are not resolved by the parties to binding arbitration in accordance with the then current AAA Commercial Rules for disputes. The arbitrator(s) shall be bound by and shall follow the then current ABA/AAA Rules of Ethics for Arbitrators.

Any arbitration proceeding under this Agreement shall be conducted in the state of Minnesota. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law and applicable rules of evidence.

Unless otherwise agreed to by both parties, the parties expressly intend that any Dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the Dispute related to this Agreement. The parties agree that any arbitration ruling by an arbitrator allowing class action

arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

If any portion of this Section or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Section or Agreement. If any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

If a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved in accordance with this Section. If the Dispute is submitted to arbitration, the termination for breach will not take effect during the arbitration proceeding.

Neither party shall be liable to the other party for punitive, exemplary, consequential, indirect or special damages, in each case, except to the extent such damages result from an award of damages in a third party claim.

This Section is the parties sole recourse for any dispute resolution and the parties waive the right to seek relief from a court of competent jurisdiction, unless otherwise required by law.

SECTION 11
MISCELLANEOUS

11.1 Notices. All notices or other communication required under this Agreement shall be in writing (which may be electronic) and shall be deemed delivered when delivered personally or by e-mail, one day after delivery by commercial overnight delivery service, or if mailed, five days after the date of mailing.

11.2 Amendment. Except as may otherwise be set forth in this Agreement, this Agreement may be amended only by both parties agreeing to the amendment in writing and complying with any and all notice and/or approval requirements of the insurance laws of the state in which United is domiciled.

11.3 Assignment; Subcontracting; Successors and Permitted Assigns. Neither United nor Vendor may assign its rights or responsibilities under this Agreement without the prior written consent of the other party, with the exception that United may assign its rights and responsibilities under this Agreement to an affiliate. With respect to any assignment of this Agreement, the parties shall comply with any and all notice or approval requirements of the

insurance laws of the state in which United is domiciled. To the extent permitted by law, Vendor shall have the right to subcontract all or a portion of its obligations to any third party or affiliate; provided, however, that (a) Vendor shall be responsible to United for those duties to the same extent that it would have been responsible without the use of an affiliate or subcontractor, and (b) Vendor will ensure that its affiliates and subcontractors comply with all the terms of this Agreement, including, without limitation, the obligation to perform the services hereunder in compliance with all applicable laws and regulations. To the extent required by any regulatory agency governing any Medicare or Medicaid or other governmental benefit plans (or as may be set forth in an Appendix) or any accreditating agency, Vendor shall provide notice to United and/or obtain consent, prior to any subcontracting of any of its responsibilities under this Agreement. This Agreement shall be binding upon, inure to the benefit of, and be specifically enforceable by and against the parties and their respective successors and permitted assigns. Nothing expressed or referred to in this Agreement will be construed to give any person or entity other than the parties hereto any rights, remedies or claims under or with respect to this Agreement.

11.4 Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the state in which United is domiciled without regard to the conflicts of laws provisions thereof.

11.5 Entire Agreement; Counterparts. This Agreement, which incorporates all exhibits, attachments, addenda, and appendices, constitutes the entire agreement between the parties in regard to the subject matter contained in this Agreement. This Agreement replaces any prior written or oral communications or agreements between the parties relating to the subject matter contained in this Agreement. In the event of a conflict between the provisions of the main body of this Agreement and an Appendix or an exhibit, the terms of the applicable Appendix or exhibit will control. The headings and titles within this Agreement are for convenience only and are not part of the Agreement. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which taken together shall constitute one and the same instrument..

11.6 Marketing; Advertising; Use of Names and Trademarks. During the term of this Agreement, the parties shall have the right to designate and make public reference to the other party by name in an accurate and factual manner, as the company providing, managing and/or arranging for the provision of services. Vendor and United shall not otherwise use the other party's name, trademarks, or service marks without prior written approval. The parties mutually agree to provide, at a minimum, forty-eight (48) hours advance notice and opportunity to comment on all press releases, advertisements or other media statements and communications regarding this Agreement, the services or the business relationship between the parties. Vendor shall obtain United's consent prior to any publication or use of such materials or communications. Notwithstanding the foregoing, if Vendor wishes to make a press release, advertisement or other media statement or communication that requires prior approval of a state or federal regulator, United shall be responsible for seeking such approval in a timely manner and Vendor agrees it will not proceed with the statement or communication until the required

approval is obtained. Nothing herein shall be construed to create a right or license to make copies of any copyrighted materials.

11.7 Excluded Individuals. Neither Vendor nor United shall employ or contract any individual or entity (a) excluded from participation in Medicare or a state health care program or (b) any entity that employs or contracts with such an individual or entity to provide services under this Agreement.

11.8 Non-waiver. The failure of either party to insist upon the strict observance or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy. Nothing in this Agreement shall be considered waived by either party unless the party claiming the waiver receives the waiver in writing signed by an authorized signatory. A waiver of one right, remedy or strict observation or performance of a provision does not constitute a waiver of any other.

11.9 Relationship Between Parties. The relationship between the parties to this Agreement is solely that of independent contractors. Nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, partnership, agency, joint venture, association or any other form of separate legal entity or organization.

11.10 Survival of Terms. Any provisions of this Agreement including any attachments hereto, that, by their nature, extend beyond the expiration or termination of this Agreement shall survive the termination of this Agreement and shall remain in effect until all such obligations are satisfied.

11.11 No Third Party Beneficiaries. This Agreement is intended solely for the benefit of the parties hereto and no third parties shall have any rights hereunder or interest herein except as explicitly provided herein.

11.12 Force Majeure. The obligations of a party under this Agreement will be suspended for the duration of any force majeure applicable to that party. The term “force majeure” means any cause not reasonably within the control of the party claiming suspension, including, without limitation, an act of God; war; riot; invasion; acts of a foreign enemy; terrorist action; weather-related disaster and governmental action. A party claiming suspension under this Section shall use its best efforts to resume performance as soon as possible.

11.13 Arm’s Length Negotiations. The parties acknowledge that the terms of this Agreement are fair and reasonable, were negotiated at arm’s length, and that the parties were given ample opportunity to review and consider this Agreement prior to execution.

11.14 Offshoring. To the extent mandated by law, contract or the applicable regulatory agency, United will notify Vendor of any requirements or restrictions for Vendor performing any of the services outside of the United States. Vendor shall comply with such requirements or restrictions.

11.15 Substantial Change. The parties may renegotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a Substantial Change which presents a fundamental departure from the risk, services, administration, costs or expenses or other assumptions or intent of the parties in entering into either this Agreement, including without limitation:

(a) A significant reduction in the number, or change in the composition of, Member enrollment;

(b) A material change in utilization or trends;

(c) A material modification of an existing Benefit Plan;

(d) Development of a new Benefit Plan;

(e) Expansion of a Service Area to a geographic area of the country not originally contemplated under this Agreement; or

(f) A significant change in any law, rule, regulation or interpretation thereof that would have a material and adverse effect on the ability of a party to receive the benefits it reasonably expects to obtain under this Agreement or renders it illegal for a party to continue to perform under this Agreement in a manner consistent with the parties' intent.

The affected party must promptly notify the other party of the Substantial Change and its desire to renegotiate this Agreement. This section does not affect either parties' right to terminate this Agreement in accordance with Section 7.1.

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IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

DENTAL BENEFIT PROVIDERS, INC.	UNITEDHEALTHCARE OF LOUISIANA, INC.
By: 	By: _____
Print Name: Karl J. Olsen	Print Name: Bridget L. Galatas
Title: President	Title: Chief Financial Officer

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

DENTAL BENEFIT PROVIDERS, INC.	UNITEDHEALTHCARE OF LOUISIANA, INC.
By: _____	By: Bridget L Galatas
Print Name: _____	Print Name: Bridget L. Galatas
Title: _____	Title: Chief Financial Officer

EXHIBIT LIST

(Add X if Exhibit is attached; add N/A if there is no Exhibit:

X	Exhibit A:	Compensation for Services Addendum (Plans; Service Areas)
X	Exhibit B:	Services Addendum
N/A	Exhibit C:	Medicare Advantage Regulatory Requirements Appendix
N/A	Exhibit D:	HMO or Insurance Specific Requirements Appendix
N/A	Exhibit E:	State Regulatory Requirements Appendix
X	Exhibit F:	Delegation of Credentialing Addendum

Any exhibits not checked or designated as N/A have been intentionally omitted.

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area	Rate	Rate Type	ASO or Full Service Benefit Plans
E&I	Commercial	EHB - Admin	Dental	N/A	[redacted]	PMPM	ASO

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

EXHIBIT B
SERVICES ADDENDUM

Dental Services

Vendor shall provide the services described in this Addendum.

To the extent required by a regulatory or accreditating agency,

(a) the parties shall document to the level of specificity required by applicable government authorities and/or United's accreditation agencies the activities relating to the services that have been delegated under this Exhibit to Vendor in accordance with the timeframes required;

(b) before activities are delegated under this Agreement, United will or has conducted a pre-assessment audit of Vendor to assess Vendor's ability to fulfill the terms of this Agreement for any delegated activities; and

(c) upon request by United, Vendor shall cooperate and participate, either telephonically or personally, in accreditation and/or state or federal regulatory audits, including interview sessions, related to the delegated activities provided under this Agreement. This section (c) shall survive termination of this Agreement, Exhibit and the delegated activities.

SECTION 1
NETWORK MANAGEMENT

1.1 Network Development. Vendor shall arrange for Participating Providers to provide Covered Services to Members. United may recommend to Vendor that certain providers become Participating Providers. In no case shall this provision be construed to obligate Vendor to contract with or make use of any particular health care facility or professional. Vendor retains full and complete rights to terminate a Participating Provider's Provider Agreement with Vendor. Vendor makes no representations or guarantees regarding the continued availability of any Participating Provider. Vendor shall provide United with electronic access in a mutually agreeable format to a listing of Participating Providers that Vendor will update monthly. In the event of termination of a Participating Provider, Vendor shall assist Members in transitioning to a new Participating Provider within a reasonable time or such timeframe as required by applicable state and/or federal law. Any material changes to the composition of the Provider network may be subject to prior written notification to the applicable state and/or federal regulatory authorities.

1.2 Participating Provider Insurance. Vendor shall require Participating Providers to procure and maintain applicable malpractice and/or professional liability insurance equal to the prevailing community standard unless (a) applicable state law or regulation requires otherwise, or (b) United provides notice in advance of implementation of other insurance requirements.

1.3 Geographic Access. Upon United's written request, Vendor shall provide United with a current listing of Participating Providers. Vendor's Participating Provider network will be sufficient to ensure that all Members within United Service Area have reasonable access to Covered Services and in accordance with applicable state and federal law or state contract availability and access requirements. If United reasonably determines that there are not sufficient Participating Providers to provide Covered Services to Members:

- United shall notify Vendor of the alleged deficiency;
- United and Vendor shall meet to discuss the alleged deficiency; and
- If appropriate, develop a mutually satisfactory plan of correction within thirty (30) days of such notice.

United shall have the ability to impose unilaterally a corrective plan of action if the parties cannot develop such a plan in a timely and mutually satisfactory manner. United shall notify Vendor in writing at least ninety (90) days prior to any modification of United's Service Area. Vendor shall use best efforts to arrange for Participating Providers in such expanded Service Area within ninety (90) days of receiving such notice, at which time the definition of Service Area in this Agreement shall include such expansion without further compliance with Section 11.2 of the Agreement.

1.4 Vendor's Provider Agreements and Manuals. Vendor's network participation requirements shall be set forth in its Provider Agreement, operations manual, and/or credentialing and recredentialing plan, all of which shall be made available to United upon written request. Vendor must have a written agreement in effect with each Participating Provider and shall ensure that its Provider Agreements and related manuals comply with all applicable laws, regulations, government programs and accrediting agency standards. Vendor understands and agrees that Vendor and Participating Providers may be subject to United's administrative guide and/or provider manual for the provision of Covered Services for certain state or federal government program Benefit Plans. The Provider Agreements will require Participating Providers to comply with all applicable obligations in this Agreement and ensure that Members have access to Participating Providers for the programs and/or products set forth in Exhibit A. Vendor and United shall work together in good faith to address any concerns United has regarding the content of such agreements and manuals.

Vendor shall cooperate with and provide to United copies of the Provider Agreements and manuals that United is required to file or submit for regulatory or accreditation purposes and agrees to work with the regulators or administrators to address any concerns regarding the content of such agreements or manuals.

If Vendor intends to make any substantial changes to its Provider Agreements or manuals that would materially affect this Agreement or require filing or submission to United's regulators or administrators, Vendor shall notify United of such proposed changes in advance of their effective dates. Vendor and United shall work together in good faith to resolve any concerns United may

have about the proposed changes and to complete any filing or submission United is required to make.

1.5 Right to Approve, Suspend, or Terminate Participating Providers. United retains the absolute right to approve, suspend or terminate a Participating Provider for participation in any or all of its Benefit Plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate, until such provider is credentialed. United shall promptly inform Vendor and the affected Participating Provider of any denial, restriction or revocation of a Participating Provider's participation status in any or all of United's Benefit Plans. In no case shall this Section be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

1.6 Discontinuing Use of a Participating Provider. Vendor shall discontinue referrals to or otherwise using a Participating Provider for Covered Services upon the occurrence of any of the following:

(a) immediately upon expiration of the cure period for a material breach; provided, however, that Vendor shall have sixty (60) days from the date it receives written notice from United identifying the Participating Provider's conduct that violates a material term of this Agreement or Vendor's agreement with the Participating Provider to cure such defect;

(b) immediately upon Vendor's receipt of written notice that the Participating Provider's license or certification has been revoked, suspended or otherwise limited;

(c) immediately upon Vendor's receipt of written notice that the Participating Provider's liability insurance has been revoked;

(d) immediately upon Vendor's receipt of written notice that the Participating Provider has been sanctioned by a state or CMS; or

(e) immediately upon termination of the Participating Provider's agreement with Vendor.

Vendor will notify United of Vendor's discontinued use of a Participating Provider to permit United to comply with its obligations under federal or state law or state contract to notify the applicable state and its Members of changes to provider networks. Vendor shall provide this notice at least thirty (30) days prior to its discontinuation of a Participating Provider. If thirty (30) days advance notice is not possible, the notice must be as soon as possible. The parties agree and acknowledge that under no circumstance shall services to Members be disrupted. Vendor agrees to abide by all applicable laws and regulations to provider appeals of termination.

SECTION 2
CREDENTIALING AND RECREDENTIALING

2.1 Participating Provider Credentialing. Vendor shall establish and maintain a credentialing and re-credentialing process to which all professional Participating Providers shall be subject in accordance with the Delegation of Credentialing Addendum, attached to this Agreement as Exhibit F. Upon United's written request, Vendor shall provide United with a copy of Vendor's

credentialing process. Vendor's credentialing process shall comply with Exhibit F of this Agreement and the applicable requirements of the National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations or another generally recognized accrediting agency ("Accrediting Agency") and for Medicare, Medicaid, and any other government business, any additional requirements under state or federal law. The services performed by Vendor under the Delegation of Credentialing Addendum shall be pursuant to the monitoring, oversight and approval of United. With reasonable prior written notice and during normal business hours, United may conduct comprehensive onsite evaluation of Vendor's credentialing procedures. Vendor shall immediately provide documentation to United related to any issue concerning quality of care or related to any investigation or inquiries by regulatory agencies of any Participating Provider.

SECTION 3
UTILIZATION MANAGEMENT AND/OR COMPLEX CASE MANAGEMENT

3.1 Utilization Management and/or Complex Case Management. Vendor shall be delegated for utilization management and/or complex case management services as designated by United. Vendor shall establish and maintain a utilization management program and/or complex case management program to which all professional Participating Providers will be subject. Upon United's written request, Vendor shall provide United with a copy of Vendor's utilization management and/or complex case management process. Vendor's process shall comply with the applicable requirements of the National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations or another generally recognized accrediting agency ("Accrediting Agency") and for Medicare, Medicaid, and any other government business, any additional requirements under state or federal law. The delegated services performed by Vendor shall be pursuant to the monitoring, oversight and approval of United. With reasonable prior written notice and during normal business hours, United may conduct comprehensive onsite evaluation of Vendor's utilization management and/or complex case management procedures.

SECTION 4
CLAIMS ADMINISTRATION

4.1 Claims Administration. Vendor shall perform certain claims administration services for claims associated with Covered Services provided to Members as described in this Section. Vendor shall arrange for Participating Providers to submit claims for Covered Services to Vendor. Claims shall be paid in accordance with the terms and conditions of the Benefit Plans, Vendor's agreements with Participating Providers, this Addendum, this Agreement, and any applicable state or federal requirements.

4.2 Benefit Administration. Vendor shall make initial determinations whether services and/or supplies requested by or on behalf of a Member or for which a Member has requested reimbursement are Covered Services.

If Vendor determines that the requested services and/or supplies are not Covered Services, Vendor shall notify the Member about the lack of coverage and the Member's rights under the Benefit Plan to appeal a denial of coverage.

4.3 Member and Provider Appeal and Grievance Process.

(a) In the event of disputes with a Member or Provider regarding coverage of Covered Services, Vendor shall refer the Member or Provider to the appropriate appeal and grievance processes under the Member's Benefit Plan. Vendor shall cooperate with United with respect to any such appeal or grievance processes. The result of the Member appeal and grievance process shall be binding on Vendor, unless Vendor notifies United that Vendor disagrees with such result within fifteen (15) business days after Vendor receives notice of the result. In such case, United or Payor may authorize coverage and pay for the provision of the services and/or supplies in dispute, and the parties shall proceed with the dispute resolution process described in Section 4.4 of this Addendum.

(b) In the event of a dispute with a Provider regarding payment, Providers will utilize Vendor's policies and procedures for the appropriate appeal and grievance process. Vendor shall ensure that its provider dispute process is in compliance with all applicable state and federal requirements for both participating and non-participating providers. Vendor will notify United of Provider disputes and provide all necessary data to United regarding the dispute, and will maintain such dispute records as required by law. United shall cooperate with Vendor with respect to any such appeal or grievance process and unless otherwise required by state or federal requirements be bound by Vendor's resolution of the dispute.

4.4 Coverage Disputes between Vendor and United or a Payor Regarding Members. In the event: (a) of a dispute between Vendor and United or a Payor regarding whether particular services and/or supplies for a Member are Covered Services for which Vendor has financial responsibility; or (b) if United or a Payor enters into a settlement agreement with a Member as a result of actual or threatened grievance, arbitration or litigation, and United or Payor and Vendor do not agree on financial liability for such services (collectively, a "Coverage Dispute"), the parties shall comply with the following Coverage Dispute resolution procedure:

(i) The Coverage Dispute shall be submitted to United's or the Payor's and Vendor's medical directors, or equivalent, for review.

(ii) The medical directors shall issue their determination within seven (7) business days after submission and receipt of appropriate and necessary information.

(iii) If there continues to be a Coverage Dispute after the medical directors' review, the parties shall submit the Coverage Dispute to the appropriate senior executive at each organization, who shall issue their determination within seven (7) business days after submission.

(iv) If there continues to be a Coverage Dispute, the affected parties may initiate dispute resolution pursuant to Section 10 of this Agreement.

4.5 Effect of Expiration or Termination. When this Agreement or this Addendum expires or is terminated, the parties agree as follows:

Vendor is administratively responsible (and is also financially responsible for the Full Service Benefit Plans) for any claims for Covered Services provided prior to the expiration or termination date, even if the claim for such Covered Services is not received until after the expiration or termination date. The applicable terms of this Addendum, including Sections 4.1 to 4.4, apply to such claims.

Vendor is also administratively responsible (and is also financially responsible for the Full Service Benefit Plans) for any claims for Covered Services provided after the expiration or termination date if the claim is related to completing Covered Services that started prior to the expiration or termination date. Completing such Covered Services is included in the payments Vendor received prior to the expiration or termination date. The applicable terms of this Addendum, including Sections 4.1 to 4.4, apply to such claims.

Vendor is not financially or administratively responsible for any other claims for Members that are related to Covered Services provided after the expiration or termination date. Vendor shall promptly forward any claims it receives for post-expiration or post-termination date Covered Services for Members that are not Vendor's responsibility to United or United's designee in a manner consistent with any agreement reached.

SECTION 5
OTHER SERVICES

5.1 General Services. In addition to the services described herein, Vendor shall provide the following:

(a) Vendor will provide United with the reports identified below regarding Covered Services. Vendor shall provide such reports to United no later than thirty (30) business days after the end of each month or calendar quarter, as appropriate or as required by statutes, laws or regulations.

(i) Vendor shall provide United, in a format specified by United, a monthly file of those Participating Providers either terminated from or added to Vendor's network to ensure that United can update its system appropriately or as required by statutes, laws or regulations.

(ii) Vendor shall provide standard monthly and quarterly cumulative reports. Vendor agrees to cooperate with United in preparing any encounter or other reports, including but not limited, denial rate reports; aged claims reports; claims

audit reports; coordination of benefits collection from third parties reports; and any other reports that may be required by any applicable state contract, state or federal regulatory agencies

(iii) Upon agreement of the parties and for an additional fee, Vendor shall provide, within a time period mutually agreed to by the parties, specialized reporting of data regarding Covered Services provided or authorized by Vendor.

(iv) Vendor and United agree that United may receive one ad hoc report at no additional cost. Additional requests, description of work, terms, schedules and rates shall be detailed and mutually agreed to by United and Vendor prior to commencement of the work.

(b) Vendor shall make commercially reasonable efforts to provide Participating Provider contact information required for basic service calls from Members. Vendor shall provide a monthly report to United of such service calls.

(c) Vendor shall cooperate with United with respect to surveys of a sample of Members who have accessed Covered Services pursuant to this Agreement and/or Participating Providers to assess satisfaction with Vendor. If areas of dissatisfaction are identified as a result of such surveys, Vendor will develop commercially reasonable corrective strategies for mutually identified areas of concern.

5.2 Quality Management. United and Vendor shall establish and maintain their own quality management programs and such other assessment and improvement programs determined to be appropriate. Vendor shall cooperate with, and shall use reasonable efforts to ensure Participating Providers cooperate with, any such reasonable and similar programs established or required by United, a Payor, or any applicable state or federal regulatory agency.

EXHIBIT C
MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
(NOT APPLICABLE)

EXHIBIT D
REGULATORY REQUIREMENTS APPENDIX
(NOT APPLICABLE)

EXHIBIT E
REGULATORY REQUIREMENTS APPENDIX
(NOT APPLICABLE)

EXHIBIT F
DELEGATED CREDENTIALING ADDENDUM

THIS DELEGATED CREDENTIALING ADDENDUM (this "Addendum"), supplements and is made a part of this Agreement.

SECTION 1
DEFINITIONS

All capitalized terms not otherwise defined herein shall have the meanings given to such terms in this Agreement.

1.1 **Complaint:** Any written or oral communication made by a Member or his or her authorized representative that expresses dissatisfaction about United, a Participating Practitioner or Component, or United's products, benefits, coverage, services or operations.

1.2 **Component:** A hospital, skilled nursing facility, outpatient surgical center, free-standing surgical center, such as stand-alone abortion clinics and multispecialty outpatient surgical centers, or a similar facility (or as otherwise defined by the Credentialing Authorities), that is required by United and the Credentialing Authorities to be Credentialed to participate in United Network.

1.3 **Credential(ed), Credentialing or Recredentialing:** The process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Practitioners or Components, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.

1.4 **Credentialing Authorities:** The National Committee for Quality Assurance ("NCQA") or other accrediting body as applicable to United, the Center for Medicare and Medicaid Services ("CMS"), as applicable, and other state and federal regulatory authorities, to the extent such authorities dictate credentialing requirements.

1.5 **Credentialing Plan:** United's policy for Credentialing and Recredentialing of Practitioners and Components. To the extent the Credentialing Plan varies from any legal requirement, the law will control. The Credentialing Plan shall also include any state or federal regulatory requirements attached to the Credentialing Plan.

1.6 **Participating Component:** A Component that is included in United Network, directly or through another entity, pursuant to a Participation Agreement.

1.7 **Participating Practitioner:** A Practitioner that is included in United Network, directly or through another entity, pursuant to a Participation Agreement.

1.8 **Participation Agreement:** For purposes of this Addendum, an agreement that sets forth the terms and conditions under which a Practitioner or a Component, either directly or through another entity, participates in Vendor's Network.

1.9 **Practitioner:** A licensed or otherwise appropriately qualified health care professional or entity who is qualified and, when applicable, duly licensed and/or certified by the state in which he, she or it is located to furnish Covered Services when acting within the scope of his, her or its license or certification.

1.10 **Quality of Care:** The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include the following: Member perspective issues, safety of the health care environment, accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of care.

1.11 **United Network:** The network of Practitioners and/or Components established by United to provide or arrange for the provision of health care services to Members.

1.12 **Vendor Network:** The network of Practitioners and/or Components established by Vendor to provide or arrange for the provision of health care services.

SECTION 2
VENDOR RESPONSIBILITIES

2.1 **Policies and Procedures.** Vendor may utilize its own policies and procedures for the performance of delegated activities set forth in this Addendum, subject to the terms and provisions hereof, and provided that such policies and procedures remain in compliance with the reasonable requirements of United, and applicable state and federal law and accreditation standards. All such policies and procedures shall be forwarded to United, on an annual basis or upon request, for ongoing review and approval.

2.2 **Compliance with Standards and Applicable Law.** Vendor shall at all times meet the applicable standards for Credentialing and Recredentialing, as required by Credentialing Authorities and as set forth in the most current Credentialing Plan. United shall provide Vendor a copy of the Credentialing Plan through regular mail or electronically. United may unilaterally change its Credentialing Plan by providing thirty (30) days prior written notice to Vendor of the changes and their effective dates; provided, however, if required by Credentialing Authorities, United may unilaterally change the Credentialing Plan immediately without prior written notice to Vendor of the changes and their effective dates. Any notice provided to Vendor under this Section may be in electronic format. Vendor shall also comply with all applicable laws related to the performance of delegated activities.

2.3 **Delegated Activities.** Vendor shall perform such delegated activities as United deems appropriate, including the Credentialing of Practitioners and Components in accordance with the Credentialing Plan, as may be amended from time to time, and the requirements set forth by the Credentialing Authorities. Vendor understands and agrees that Practitioners and Components may not provide health care services to a Member unless and until such Practitioners and Components are properly Credentialed and have executed or are otherwise subject to a Participation Agreement. Vendor will not communicate anything to the contrary to a Practitioner or Component.

2.4 **Credentialing of Practitioners.** The Credentialing of Practitioners by Vendor shall include, but is not limited to:

(a) establishing and maintaining credentialing standards, policies and procedures;
(b) receiving the provider's application, reapplication and attestation, including documentation required under state and federal rules, regulations and any applicable contract between United and a state;
(c) conducting office site visits as required by applicable law and/or state contract and medical record keeping assessments;
(d) recredentialing Practitioner every thirty-six (36) months, unless otherwise required by applicable law, but confirming the Practitioner has not been denied Credentialing from United in the previous twenty-four (24) months;
(e) confirming the Practitioner has active hospital staff privileges at a participating hospital, if applicable to Practitioner's practice;
(f) confirming the Practitioner is Medicaid-enrolled and agrees to comply with all pertinent Medicaid regulations as applicable for participation in Medicaid programs
(g) making decisions on Credentialing; and

(h) the ongoing monitoring and evaluation of Complaints, sanctions on licenses, Medicare/Medicaid Complaints, and Quality of Care issues.

(i) primary source verification, where applicable, of the Practitioner's education, including successful completion of a residency program, board certifications, current licensure or certification and any sanctions or limitations thereon;

(j) registration with the Drug Enforcement Agency;

(k) possession of a State Controlled Dangerous Substance Certificate, as applicable;

(l) current, active malpractice insurance or state-approved alternative;

(m) malpractice history;

(n) work history; and

(o) verification that the Practitioner has not opted out of participation with Medicare, is not ineligible, excluded or debarred and does not have any restrictions, sanctions, censures or other disciplinary action (other than action regarding incomplete medical records) against him/her by any state or county medical association, medical staff, hospital, state or federal programs, including but not limited to, Medicare or Medicaid.

2.5 **Credentialing of Components.** If the Vendor Network includes Components, Vendor shall Credential the Components on behalf of United. The Credentialing of Components shall include, but is not limited to:

(a) establishing and maintaining Credentialing standards, policies and procedures;
(b) verification of current licensure or certification and any sanctions or limitations thereon;
(c) verification that the Component is not ineligible, excluded or debarred and does not have any restrictions, sanctions or other disciplinary action against it by any state or federal programs;
(d) verification of current, active malpractice insurance or state-approved alternative;
(e) appropriate accreditation, certification or satisfactory alternative or a passing score on Component site visits;
(f) making decisions on Credentialing; and
(g) the ongoing monitoring and evaluation of Complaints, sanctions on licenses, Medicare/Medicaid Complaints, and Quality of Care issues.

2.6 **Right of Appeal.** If Vendor makes a decision to suspend or terminate a Participating Practitioner or Participating Component from Vendor's network, Vendor shall, in accordance with Vendor's and United's credentialing policies and procedures, offer such Participating Practitioner or Component the right to appeal or request a fair hearing. Vendor shall conduct the appeals process and report the action, as required by the Credentialing Authorities.

2.7 **Audit Participation.** Vendor shall fully cooperate and participate, either telephonically or personally, in audits conducted by Credentialing Authorities, including interview sessions, upon fourteen (14) calendar days notice from United, unless the Credentialing Authorities require a shorter timeframe. This Section shall survive any termination of this Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.8 **Records.** Unless applicable statutes or regulations require a longer time period, Vendor shall retain all information and records related to this Addendum according to United's record retention policies, or for at least ten (10) years, or as otherwise required by law. United, Credentialing Authorities and any federal, state or local governmental official or their authorized representatives who audit United shall have access to all records or copies which are pertinent to and involve transactions related to this Addendum if such access is necessary to comply with United's policies, applicable accreditation standards, statutes, or regulations. Photocopying and mailing of records pursuant to this section shall be at no charge to United. United and Vendor

shall maintain the privacy of all information regarding Members, Covered Services Participating Practitioners and Participating Components in accordance with applicable statutes and regulations. This Section shall survive any termination of this Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.9 **Improvement Action Plan.** In the event that, during an audit or any other time during the term of this Addendum, United discovers any deficiency(ies) in Vendor's delegated activities, Vendor shall develop an Improvement Action Plan for the specific activity that United determines to be deficient. The Improvement Action Plan shall include specifics of and timelines for correcting any deficiencies or issues contained in the audit report to Vendor. Vendor shall implement the Improvement Action Plan within the specified timeframes. In the event the Improvement Action Plan is not developed and/or implemented within such timeframes, United may revoke all or certain delegated activities pursuant to Section 3.3 of this Addendum. If deficiencies are identified, United retains the right to increase its monitoring, evaluations, and audits of Vendor until the deficiencies are corrected.

2.10 **Documentation and Information.** Vendor shall provide to United the following documentation and information according to the time periods listed below:

(a) **Inquiries and Investigations.** Within ten (10) business days of Vendor's knowledge of actions taken as a result of any inquires or investigation by regulatory agencies, or Quality of Care issues investigated by Vendor, that result in the limitation, restriction, suspension or termination of a Participating Practitioner's or Component's ability to provide services to Members, Vendor shall provide United with documentation related to such inquires or investigations. Vendor is not required to provide United with information that is peer review protected or documents and deliberation considered confidential or privileged by HCQIA (Health Care Quality Improvement Act-1986) or according to state peer review laws.

(b) **United Network Updates.** Vendor shall provide United with information about Participating Practitioners or Components who have changes to their demographic information, who have been Credentialed or Recredentialed, or who have been terminated, suspended, or restricted from participating in Vendor's network as changes occur, but no later than five business days from the time such changes occur. Such information shall be in an electronic format mutually agreed upon by the parties and shall include all information United needs to meet its database requirements. A sample of the format, content and where to submit this information shall be made available to Vendor on an electronic basis. United may unilaterally change its Credentialing and Recredentialing database requirements by providing thirty (30) days advance notice, in an electronic format, to Vendor of the changes and their effective date.

(c) **Improvement Action Plan Items.** Every six (6) months after the Effective Date of this Agreement, Vendor shall provide United with any outstanding Improvement Action Plan items.

(d) **List of Participating Practitioners and Components.** Upon United's request, which will be at least semi-annually and annually, Vendor shall provide United with a complete list of Participating Practitioners and Components currently active in United Network and Credentialed by Vendor.

SECTION 3
COMPANY'S RESPONSIBILITIES

3.1 **Pre-Delegation Assessment.** The parties acknowledge that United has completed a pre-assessment audit of Vendor to assess its ability to fulfill the terms of this Addendum.

3.2 **United Delegation, Oversight, Monitoring and Audit.** United shall perform oversight and monitoring of Vendor's performance under this Addendum, including but not limited to, review of the documentation and information related to delegated activities, as set forth in Section 2.10 of this Addendum. At any time, but at least annually, United will audit records and documents related to the activities performed under this Addendum, including but not limited to Vendor's Credentialing and Recredentialing files. United, in its sole discretion, will conduct desk-top review of Vendor's written policies and procedures and will perform file review audits at the site of Vendor. United will provide written notice of annual audits at least thirty (30) calendar days prior to the audit. United shall provide a report of its audit findings to Vendor within thirty (30) calendar days of the audit's conclusion. For all additional audits, United shall provide at least fourteen (14) calendar days prior written notice, unless state or federal regulators or other Credentialing Authorities require a shorter timeframe. The audit notes shall include a list of the records to be reviewed.

3.3 **Revocation of Delegation.** United may revoke the delegation of some or all of the activities which Vendor is obligated to perform under this Addendum in the event Vendor fails to meet the requirements of United, applicable law, regulations, or accreditation standards in the performance of the delegated activity(ies).

3.4 **Right to Approve, Suspend, or Terminate Practitioners.** United retains the absolute right to approve or reject a Practitioner or Component for participation in United Network or in any or all of its Benefit Plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate, until such Practitioner or Component is Credentialed. United shall promptly inform Vendor and the affected Practitioner or Component of any denial, restriction or revocation of the provider's participation status in United Network or a Benefit Plan, as determined by United. United also retains the absolute right to terminate or suspend any Participating Practitioners or Components from participation in

United Network or in any or all of its Benefit Plans. In no case shall this Section be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

SECTION 4
TERM

4.1 **Term.** This Addendum shall run co-terminously with this Agreement, except that United may revoke any or all delegated activities at any time pursuant to Section 3.3.

4.2 **Records Upon Termination.** Upon the effective date of termination of this Agreement or revocation of all Delegated Activities pursuant to Section 3.3, Vendor shall provide United with a list of all Participating Practitioners and Participating Components that Vendor has Credentialed on United's behalf. Also, upon request by United, and if agreed to by Vendor, Vendor shall provide United with copies of Vendor's Credentialing and Recredentialing files that pertain to this Addendum. Such files shall be provided to United no more than thirty (30) days after the effective date of termination of this Agreement or revocation of all Delegated Activities pursuant to Section 3.3 of this Addendum.

SECTION 5
SUB-DELEGATION

Under certain circumstances, United may allow Vendor to sub-delegate all or a part of its delegated activities under this Addendum to another entity. Prior to any such sub-delegation arrangement, Vendor must:

(a) Warrant that the sub-delegation agreement between Vendor and the sub-delegated organization meets the requirements of Credentialing Authorities and all terms and provisions of this Addendum;
(b) Agree to oversee and perform audits of those activities it has sub-delegated to another entity in accordance with the requirements of Credentialing Authorities and this Addendum;
(c) Provide all reports to United that are required under this Addendum;
(d) Not enter into the sub-delegation agreement until it receives United's prior written approval; and
(e) Assure that Vendor's ownership interest in the sub-delegate is less than one-hundred percent (100%).

FIRST AMENDMENT
TO DENTAL SERVICES AGREEMENT

This First Amendment to the Dental Services Agreement (this "Amendment"), is entered into as of January 1, 2015 (the "Effective Date") by and between Dental Benefit Providers, Inc. ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Dental Services Agreement effective January 1, 2014 (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, attached hereto.

3. The attached "Exchange Regulatory Appendix" is hereby added as Exhibit G. The Exhibit list is amended to add "X Exhibit G: Exchange Regulatory Appendix".

4. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: David I. Bailey

Print Title: President

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Bridget L. Galatas

Print Title: Chief Financial Officer

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: _____

Print Title: _____

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Bridget L. Galatas

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area	Rate	Rate Type	ASO or Full Service Benefit Plans
E&I	Commercial	EHB - Admin	Dental	-	[redacted]	PMPM	ASO

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

EXHIBIT G

EXCHANGE REGULATORY APPENDIX

[SEE ATTACHED]

EXHIBIT G
EXCHANGE REGULATORY APPENDIX

THIS EXCHANGE REGULATORY APPENDIX (this "Appendix") supplements and is made part of the Agreement and shall survive termination of the Agreement to the extent it or applicable law imposes continuing obligations.

SECTION 1
APPLICABILITY

United is operating as a certified Qualified Health Plan Issuer ("QHP Issuer") in one or more public Health Care Exchanges ("Exchange") created under the terms of the Federal Patient Protection and Affordable Care Act ("PPACA") and any implementing State law. United may be delegating certain of its QHP Issuer's activities, reporting responsibilities, and/or other obligations, to Vendor.

This Appendix applies solely to the services performed and provided with respect to any Exchange business delegated by United to Vendor pursuant to the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control, except as required by applicable law. Terms in this Agreement shall be as defined in PPACA, as supplemented by any applicable State Exchange law.

SECTION 2
PROVISIONS

This Appendix is intended to comply with Exchange laws and substantive requirements.

1. The delegated activities and reporting responsibilities are set forth in the Agreement to which this Appendix is attached. To the extent such delegated activities and reporting responsibilities serve Exchange business, they are designated as "QHP Services".

2. Vendor acknowledges and agrees that United may revoke the delegated activities and reporting standards of Vendor or specify other remedies, for the respective Exchange, in instances where the U.S. Department of Health and Human Services ("HHS"), a State Exchange regulator, or United determines that such parties have not performed satisfactorily. To the extent that HHS or a State Exchange regulator directs the revocation, United shall provide immediate written notice of such to Vendor, and such revocation shall become effective as directed by HHS or the State Exchange regulator. Vendor shall cooperate with United regarding the transition of any QHP Services that have been revoked by United.

3. Vendor must comply with all applicable laws and regulations relating to the standards specified in 45 CFR §156.340, as it may be amended from time to time, and all other Federal and/or State laws relevant to United's Exchange business being serviced.

4. Vendor must permit access by the Secretary of HHS and the Office of Inspector General or their designees, in the case of Federally Facilitated Exchange ("FFE") business, or comparable State regulators, in the case of State Exchange business, in connection with their right to evaluate through audit, inspection, or other means, to Vendor's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the United's obligations as a QHP Issuer in accordance with Federal standards under 45 CFR §156.340, as it may be amended from time to time, with all records retained for at least 10 years from the final date of the Agreement period or such lesser period which may be specified in State law for State Exchanges.

5. If submitting FFE data is involved, Vendor is bound by the terms of United's "Agreement between Qualified Health Plan Issuer and The Centers for Medicare and Medicaid Services" or any applicable trading partners or comparable State Exchange agreement, to test its software, and receive United's approval of software as being in the proper format and compatible with the FFE or the applicable State system.

6. If any State Exchange or HHS for FFEs requires additional specific provisions to be in United's agreement with any delegated or downstream entity, they will be provided to Vendor by United and are incorporated herein by reference or by attaching a copy of such provisions to this Exchange Regulatory Appendix.

7. If Vendor delegates any QHP Services to a downstream entity (as such term is defined in 45 C.F.R. §156.20), Vendor shall provide written advance notification to United of such delegated activities and reporting responsibilities before the applicable effective date of the delegation under federal regulations, Vendor shall bind the downstream entity to all the terms of this Appendix, including providing for revocation of the delegated activities.

SECOND AMENDMENT
TO DENTAL SERVICES AGREEMENT

This Second Amendment to the Dental Services Agreement (this "Amendment"), is entered into as of August 1, 2015 (the "Effective Date") by and between Dental Benefit Providers, Inc., 6220 Old Dobbin Lane, Liberty 6, Suite 200, Columbia, MD 21045 ("Vendor") and UnitedHealthcare of Louisiana, Inc., 3838 N. Causeway Blvd, Suite 3225, Metairie, LA 70002 ("United").

WHEREAS, the parties entered into a Dental Services Agreement effective January 1, 2014 (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. The rate chart in Section 1 of Exhibit A of the Agreement shall now include the following:

Segment	Line of Business	Service	Service Type	Service Area	Rate	Rate Type	ASO or Full Service Benefit Plans
C&S	Medicaid	LA Adult Medicaid Value Add	Dental	-	[redacted]	PMPM	ASO

3. The attached "Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix" is hereby added as Exhibit E. The Exhibit list is amended to delete and replace "N/A" with "X" for Exhibit E: State Regulatory Requirements Appendix.

4. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: David I. Bailey

Print Title: President

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: _____

Print Title: _____

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: _____

Print Title: _____

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Eric H. Johnson

Print Title: CFO UnitedHealthcare Gulf States

Exhibit E

Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the Subcontract between UnitedHealthcare Insurance Company, contracting on behalf of itself or one of its Affiliates (collectively, "United") and Subcontractor.

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the State of Louisiana's Bayou Health and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company. UnitedHealthcare of Louisiana, Inc. is an Affiliate.

2.2 **Covered Person:** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or DHH:** The Louisiana Department of Health and Hospitals.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract(s) with DHH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Bayou Health and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Covered Services; Definitions Related to Coverage. Provider shall follow the State Contract's requirements for the provision of Covered Services. A description of the package of benefits offered by DHH under the State Program is available on the DHH website at http://www.makingmedicaidbetter.com/. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be based on the individual's medical needs and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR Part 438.114(a) and § 1932(b)(2) of the Social Security Act of 1935 (42 U.S.C. §

1396u-2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition. Emergency Services also include services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). There are no prior authorization requirements for Emergency Services.

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial or non-Medicaid/CHIP members or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and

obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. Subcontractor and Provider shall accept the final payment made by United as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the Covered Persons(s). Covered Person shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. At all times during the Agreement, Subcontractor shall, and shall ensure Provider indemnifies, defends, protects, and holds harmless DHH and any of its officers, agents, and employees from:

(a) Any claims, losses, or suits relating to activities undertaken by Subcontractor and/or Provider pursuant to the Agreement or pursuant to the State Contract;

(b) Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for Subcontractor and/or Provider in connection with performance of the Agreement or in connection with performance of the State Contract;

(c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Provider and/or Subcontractor, its agents, officers, employees, or contractors in performance of the Agreement or in performance of the State Contract;

(d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor and/or Provider, its agents, officers, employees, or contractors, by Subcontractor's and/or Provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the State Contract, or by federal or State regulations or statutes;

(e) Any failure of Subcontractor and/or Provider, its agents, officers, employees, or contractors, to observe federal or State laws, including but not limited to labor laws and minimum wage laws;

(f) Any claims for damages, losses, or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

(g) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor and/or Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of United, Subcontractor, Provider, or DHH (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), United, Subcontractor, Provider, or DHH will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the State Contract remains in full force and effect, United shall be liable for authorizing services required in accordance with the State Contract.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records,

to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, DHH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Retention. Subcontractor shall, and shall require Provider to retain all administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by DHH (whether paper or electronic) for the later of: (i) six (6) years from the expiration date of the State Contract, including any extension(s) thereof; or (ii) for Covered Person records, for six (6) years after the last payment was made for services provided to the Covered Person (an exception to this requirement includes records pertaining to once in a lifetime events, including but not limited to appendectomy and amputations, etc., which must be retained indefinitely and may not be destroyed); or (iii) such other period as required by law. Notwithstanding the foregoing, if the records are under review or audit or related to any matter in litigation, such records shall be retained until completion of the audit, review or litigation and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

The above record retention requirements pertain to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least six (6) years, commencing from the last date of treatment.

(d) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to DHH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Inspection, Audit and Evaluation

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that DHH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the

quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as often as they may deem necessary during the State Contract period and for a period of six (6) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

(b) By DHH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require that Provider understand that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not

identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Subcontractor shall, and shall require Provider to notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract and DHH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract and DHH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and DHH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the DHH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's and/or Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.11 Excluded Individuals. By signing the Agreement, Subcontractor certifies, and shall require Provider to certify to the best of Subcontractor's and Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under either § 1128 or § 1128A of the Social Security Act;

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion

information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. United will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

4.12 Cultural Competency. Subcontractor shall, and shall require Provider to deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Subcontractor shall, and shall require Provider to take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Agreement must be submitted to United to submit to the Department for prior approval. In addition, Subcontractor shall, and shall require Provider to comply with the State Contract's requirements related to marketing communications.

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist DHH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network, employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA)
Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies,

detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Outstanding Claim Information. In the event of termination of the Agreement, Subcontractor shall, and shall require Provider to promptly supply to United or its designee all information necessary for the reimbursement of any outstanding Medicaid claims.

4.16 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.17 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in DHH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information.

4.18 Quality Assessment/Utilization Management Review. Subcontractor shall, and shall require Provider to adhere to the State Program's Quality Assessment and Performance Improvement (QAPI) program requirements, as outlined in the State Contract and the Quality Companion Guide, which are incorporated herein by reference and shall be furnished to Subcontractor and/or Provider upon request. Subcontractor shall, and shall require Provider to cooperate with United's QAPI and utilization management (UM) programs, which adhere to all DHH QAPI and UM program requirements. Subcontractor agrees, and shall require Provider to agree to participate and cooperate in any internal or external quality assessment review, utilization management, or grievance procedures established by United and/or the Department or its designee, whether such review or procedures are announced or unannounced.

4.19 Insurance. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. DHH and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider.

4.20 Licensing Requirements. Subcontractor represents, and shall require that Provider represent that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate Louisiana licensing body or standard-setting agency, as

applicable. Subcontractor represents, and shall require that Provider represent that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Subcontractor represents, and shall require Provider to represent that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the Office of the Louisiana Attorney General. Subcontractor shall, and shall require Provider to maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Subcontractor and Provider by United under the Agreement. If at any time during the term of the Agreement, Subcontractor and/or Provider are not properly licensed as described in this Section, Subcontractor shall, and shall require Provider to discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

4.21 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.22 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United.

4.23 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.24 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.25 Data and Reports. Subcontractor shall, and shall ensure Provider submits to United all reports and clinical information which United or DHH may require for reporting purposes pursuant to the State Contract, including but not limited to encounter data, HEDIS, AHRQ and EPSDT data and reports, where applicable. Provider shall utilize DHH's Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations. As applicable, if United has entered into alternative reimbursement arrangements with Subcontractor and/or Provider (with prior approval

by the Department), Subcontractor and Provider are required to submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by United. NOTE: United is not allowed to enter into alternative reimbursement arrangements with FQHCs or RHCs.

4.26 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or DHH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 180 days from the date of service.

4.27 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.28 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by DHH.

4.29 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the scope of Subcontractor's and/or Provider's practice.

4.30 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.31 Appeals and Grievances. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with DHH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have correct and adequate supply of such public notices.

4.32 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that DHH has the right to direct United to impose financial

consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

4.33 Primary Care Provider ("PCP") Linkages. If Provider is a PCP, Subcontractor shall require Provider to stipulate by signing an agreement that Provider's total number of Medicaid/CHIP members for the State Program will not exceed 2,500 lives per full-time physician or 1,000 lives per mid-level practitioner or physician extender up to a cap of 2,500 lives. Prior to executing an Agreement, Subcontractor, Provider and United shall specify the number of linkages United may link to Provider.

4.34 Birth Registration. As applicable, Subcontractor shall ensure Provider registers all births through LEERS (Louisiana Electronic Event Registration System) administered by the DHH/Vital Records Registry. Hospital Providers must notify United and DHH of the birth of a newborn when the mother is a member of United, complete the web-based DHH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to DHH.

4.35 Laboratory Services. If Provider performs laboratory services, Subcontractor shall ensure Provider meets all applicable State and federal requirements, including but not limited to 42 CFR Sections 493.1 and 493.3, as may be amended from time to time. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Subcontractor shall require that Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Subcontractor shall further ensure Provider provides a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

4.36 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall ensure Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Agreement. Subcontractor understands, and shall ensure Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.37 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

4.38 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

4.39 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

4.40 Advance Directives. Subcontractor shall, and shall ensure Provider complies with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

4.41 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

3.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and applicants.

3.43 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

SECTION 5
UNITED REQUIREMENTS

5.1 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract

if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6
OTHER REQUIREMENTS

6.1 State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any requirement or provision of the Agreement or this Appendix is determined by DHH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Agreement and this Appendix shall remain in full force and effect.

6.2 Ongoing Monitoring. As required under the State Contract, United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Agreement and shall perform periodic formal reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or DHH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established by DHH in the State Contract and DHH-issued guides.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of DHH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and DHH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that DHH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the State Contract. United will submit and obtain prior approval from DHH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of DHH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 Health Care-Acquired/Preventable Conditions. United and Subcontractor acknowledge and agree that United is prohibited from making payments to Subcontractor for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by DHH.

6.10 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.11 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor

acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by DHH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

6.12 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.13 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.16 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

THIRD AMENDMENT
TO THE DENTAL SERVICES AGREEMENT

This Third Amendment to the Dental Services Agreement (this "Amendment"), is entered into as of April 1, 2016 (the "Amendment Effective Date") by and between Dental Benefit Providers, Inc. ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Dental Services Agreement effective January 1, 2014, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Exhibit F, "Delegated Credentialing Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit F, "Delegated Credentialing Addendum", attached hereto. The Exhibit List of the Agreement is amended to delete X Exhibit F: Delegation of Credentialing Addendum and replace it with X Exhibit F: Delegated Credentialing Addendum.

4. The attached "Third Party Administrator and Other Services Provisions" is hereby added to the Agreement as Exhibit H, "Third Party Administrator Appendix" attached hereto. The Exhibit List is amended to add X Exhibit H: Third Party Administrator Requirements Appendix.

5. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: David I. Bailey

Print Title: President

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Eric H. Johnson

Print Title: Chief Financial Officer

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: _____

Print Title: _____

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Eric H. Johnson

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	All Dental Plans*	Dental		[redacted]	PMPM	ASO
E&I	Commercial	EHB - Admin	Dental		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter or longer than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any Cost Sharing Reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such Cost Sharing Reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

EXHIBIT F

DELEGATED CREDENTIALING ADDENDUM

[SEE ATTACHED]

EXHIBIT F

DELEGATED CREDENTIALING ADDENDUM

THIS DELEGATED CREDENTIALING ADDENDUM (this "Addendum"), supplements and is made a part of this Agreement.

SECTION 1
DEFINITIONS

All capitalized terms not otherwise defined herein shall have the meanings given to such terms in this Agreement.

1.1 **Complaint:** Any written or oral communication made by a Member or his or her authorized representative that expresses dissatisfaction about United, a Participating Practitioner or Component, or United's products, benefits, coverage, services or operations.

1.2 **Component:** A hospital, skilled nursing facility, outpatient surgical center, free-standing surgical center, such as stand-alone abortion clinics and multispecialty outpatient surgical centers, or a similar facility (or as otherwise defined by the Credentialing Authorities), that is required by United and the Credentialing Authorities to be Credentialed to participate in United Network.

1.3 **Credential(ed), Credentialing or Recredentialing:** The process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Practitioners or Components, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.

1.4 **Credentialing Authorities:** The National Committee for Quality Assurance ("NCQA") or other accrediting body as applicable to United, the Center for Medicare and Medicaid Services ("CMS"), as applicable, and other state and federal regulatory authorities, to the extent such authorities dictate credentialing requirements.

1.5 **Credentialing Plan:** United's policy for Credentialing and Recredentialing of Practitioners and Components. To the extent the Credentialing Plan varies from any legal requirement, the law will control. The Credentialing Plan shall also include any state or federal regulatory requirements attached to the Credentialing Plan.

1.6 **Participating Component:** A Component that is included in United Network, directly or through another entity, pursuant to a Participation Agreement.

1.7 **Participating Practitioner:** A Practitioner that is included in United Network, directly or through another entity, pursuant to a Participation Agreement.

1.8 **Participation Agreement:** For purposes of this Addendum, an agreement that sets forth the terms and conditions under which a Practitioner or a Component, either directly or through another entity, participates in Vendor's Network.

1.9 **Practitioner:** A licensed or otherwise appropriately qualified health care professional or entity who is qualified and, when applicable, duly licensed and/or certified by the state in which he, she or it is located to furnish Covered Services when acting within the scope of his, her or its license or certification.

1.10 **Quality of Care:** The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include the following: Member perspective issues, safety of the health care environment, accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of care.

1.11 **United Network:** The network of Practitioners and/or Components established by United to provide or arrange for the provision of health care services to Members.

1.12 **Vendor Network:** The network of Practitioners and/or Components established by Vendor to provide or arrange for the provision of health care services.

SECTION 2
VENDOR RESPONSIBILITIES

2.1 **Policies and Procedures.** Vendor may utilize its own policies and procedures for the performance of delegated activities set forth in this Addendum, subject to the terms and provisions hereof, and provided that such policies and procedures remain in compliance with the reasonable requirements of United, and applicable state and federal law and accreditation standards. All such policies and procedures shall be forwarded to United, on an annual basis or upon request, for ongoing review and approval.

2.2 **Compliance with Standards and Applicable Law.** Vendor shall at all times meet the applicable standards for Credentialing and Recredentialing, as required by Credentialing Authorities and as set forth in the most current Credentialing Plan. United shall provide Vendor a copy of the Credentialing Plan through regular mail or electronically. United may unilaterally change its Credentialing Plan by providing thirty (30) days prior written notice to Vendor of the changes and their effective dates; provided, however, if required by Credentialing Authorities, United may unilaterally change the Credentialing Plan immediately without prior written notice to Vendor of the changes and their effective dates. Any notice provided to Vendor under this Section may be in electronic format. Vendor shall also comply with all applicable laws related to the performance of delegated activities.

2.3 **Delegated Activities.** Vendor shall perform such delegated activities as United deems appropriate, including the Credentialing of Practitioners and Components in accordance with the Credentialing Plan, as may be amended from time to time, and the requirements set forth by the Credentialing Authorities. Vendor understands and agrees that Practitioners and Components

may not provide health care services to a Member unless and until such Practitioners and Components are properly Credentialed and have executed or are otherwise subject to a Participation Agreement. Vendor will not communicate anything to the contrary to a Practitioner or Component.

2.4 **Credentialing of Practitioners.** The Credentialing of Practitioners by Vendor shall include, but is not limited to:

(a) establishing and maintaining credentialing standards, policies and procedures;
(b) receiving the provider's application, reapplication and attestation, including documentation required under state and federal rules, regulations and any applicable contract between United and a state;
(c) conducting office site visits as required by applicable law and/or state contract and medical record keeping assessments;
(d) recredentialing Practitioner every thirty-six (36) months, unless otherwise required by applicable law,
(e) confirming the Practitioner has active hospital staff privileges at a participating hospital, if applicable to Practitioner's practice;
(f) confirming the Practitioner is Medicaid-enrolled and agrees to comply with all pertinent Medicaid regulations as applicable for participation in Medicaid programs
(g) making decisions on Credentialing; and
(h) the ongoing monitoring and evaluation of Complaints, sanctions on licenses, Medicare/Medicaid Complaints, and Quality of Care issues.
(i) primary source verification, where applicable, of the Practitioner's education, including successful completion of a residency program, board certifications, current licensure or certification and any sanctions or limitations thereon;
(j) registration with the Drug Enforcement Agency as applicable;
(k) possession of a State Controlled Dangerous Substance Certificate, as applicable;
(l) current, active malpractice insurance or state-approved alternative;
(m) malpractice history;
(n) work history; and
(o) verification that the Practitioner has not opted out of participation with Medicare, is not ineligible, excluded or debarred and does not have any restrictions, sanctions, censures or other disciplinary action (other than action regarding incomplete medical records) against him/her by any state or county medical association, medical staff, hospital, state or federal programs, including but not limited to, Medicare or Medicaid.

2.5 **Credentialing of Components.** If the Vendor Network includes Components, Vendor shall Credential the Components on behalf of United. The Credentialing of Components shall include, but is not limited to:

(a) establishing and maintaining Credentialing standards, policies and procedures;
(b) verification of current licensure or certification and any sanctions or limitations thereon;

(c) verification that the Component is not ineligible, excluded or debarred and does not have any restrictions, sanctions or other disciplinary action against it by any state or federal programs;

(d) verification of current, active malpractice insurance or state-approved alternative;

(e) appropriate accreditation, certification or satisfactory alternative or a passing score on Component site visits;

(f) making decisions on Credentialing

2.6 **Right of Appeal.** If Vendor makes a decision to suspend or terminate a Participating Practitioner or Participating Component from Vendor's network, Vendor shall, in accordance with Vendor's and United's credentialing policies and procedures, offer such Participating Practitioner or Component the right to appeal or request a fair hearing. Vendor shall conduct the appeals process and report the action, as required by the Credentialing Authorities.

2.7 **Audit Participation.** Vendor shall fully cooperate and participate, either telephonically or personally, in audits conducted by Credentialing Authorities, including interview sessions, upon fourteen (14) calendar days notice from United, unless the Credentialing Authorities require a shorter timeframe. This Section shall survive any termination of this Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.8 **Records.** Unless applicable statutes or regulations require a longer time period, Vendor shall retain all information and records related to this Addendum according to United's record retention policies, or for at least ten (10) years, or as otherwise required by law. United, Credentialing Authorities and any federal, state or local governmental official or their authorized representatives who audit United shall have access to all records or copies which are pertinent to and involve transactions related to this Addendum if such access is necessary to comply with United's policies, applicable accreditation standards, statutes, or regulations. Photocopying and mailing of records pursuant to this section shall be at no charge to United. United and Vendor shall maintain the privacy of all information regarding Members, Covered Services Participating Practitioners and Participating Components in accordance with applicable statutes and regulations. This Section shall survive any termination of this Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.9 **Improvement Action Plan.** In the event that, during an audit or any other time during the term of this Addendum, United discovers any deficiency(ies) in Vendor's delegated activities, Vendor shall develop an Improvement Action Plan for the specific activity that United determines to be deficient. The Improvement Action Plan shall include specifics of and timelines for correcting any deficiencies or issues contained in the audit report to Vendor. Vendor shall implement the Improvement Action Plan within the specified timeframes. In the event the Improvement Action Plan is not developed and/or implemented within such timeframes, United may revoke all or certain delegated activities pursuant to Section 3.3 of this Addendum. If deficiencies are identified, United retains the right to increase its monitoring, evaluations, and audits of Vendor until the deficiencies are corrected.

2.10 **Documentation and Information.** Vendor shall provide to United the following documentation and information according to the time periods listed below:

(a) **Inquiries and Investigations.** Within ten (10) business days of Vendor's knowledge of actions taken as a result of any inquires or investigation by regulatory agencies, or Quality of Care issues investigated by Vendor, that result in the limitation, restriction, suspension or termination of a Participating Practitioner's or Component's ability to provide services to Members, Vendor shall provide United with documentation related to such inquires or investigations. Vendor is not required to provide United with information that is peer review protected or documents and deliberation considered confidential or privileged by HCQIA (Health Care Quality Improvement Act-1986) or according to state peer review laws.

(b) **Improvement Action Plan Items.** Every six (6) months after the Effective Date of this Agreement, Vendor shall provide United with any outstanding Improvement Action Plan items.

(c) **List of Participating Practitioners and Components.** Upon United's request, which will be at least semi-annually and annually, Vendor shall provide United with a complete list of Participating Practitioners and Components currently active in United Network and Credentialed by Vendor.

SECTION 3
COMPANY'S RESPONSIBILITIES

3.1 **Pre-Delegation Assessment.** The parties acknowledge that United has completed a pre-assessment audit of Vendor to assess its ability to fulfill the terms of this Addendum.

3.2 **United Delegation, Oversight, Monitoring and Audit.** United shall perform oversight and monitoring of Vendor's performance under this Addendum, including but not limited to, review of the documentation and information related to delegated activities, as set forth in Section 2.10 of this Addendum. At any time, but at least annually, United will audit records and documents related to the activities performed under this Addendum, including but not limited to Vendor's Credentialing and Recredentialing files. United, in its sole discretion, will conduct desk-top review of Vendor's written policies and procedures and will perform file review audits at the site of Vendor. United will provide written notice of annual audits at least thirty (30) calendar days prior to the audit. United shall provide a report of its audit findings to Vendor within thirty (30) calendar days of the audit's conclusion. For all additional audits, United shall provide at least fourteen (14) calendar days prior written notice, unless state or federal regulators or other Credentialing Authorities require a shorter timeframe. The audit notes shall include a list of the records to be reviewed.

3.3 **Revocation of Delegation.** United may revoke the delegation of some or all of the activities which Vendor is obligated to perform under this Addendum in the event Vendor fails to meet the requirements of United, applicable law, regulations, or accreditation standards in the performance of the delegated activity(ies).

3.4 **Right to Approve, Suspend, or Terminate Practitioners.** United retains the absolute right to approve or reject a Practitioner or Component for participation in United Network or in any or all of its Benefit Plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate, until such Practitioner or Component is Credentialed. United shall promptly inform Vendor and the affected Practitioner or Component of any denial, restriction or revocation of the provider's participation status in United Network or a Benefit Plan, as determined by United. United also retains the absolute right to terminate or suspend any Participating Practitioners or Components from participation in United Network or in any or all of its Benefit Plans. In no case shall this Section be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

SECTION 4
TERM

4.1 **Term.** This Addendum shall run co-terminously with this Agreement, except that United may revoke any or all delegated activities at any time pursuant to Section 3.3.

4.2 **Records Upon Termination.** Upon the effective date of termination of this Agreement or revocation of all Delegated Activities pursuant to Section 3.3, Vendor shall provide United with a list of all Participating Practitioners and Participating Components that Vendor has Credentialed on United's behalf. Also, upon request by United, and if agreed to by Vendor, Vendor shall provide United with copies of Vendor's Credentialing and Recredentialing files that pertain to this Addendum. Such files shall be provided to United no more than thirty (30) days after the effective date of termination of this Agreement or revocation of all Delegated Activities pursuant to Section 3.3 of this Addendum.

SECTION 5
SUB-DELEGATION

Under certain circumstances, United may allow Vendor to sub-delegate all or a part of its delegated activities under this Addendum to another entity. Prior to any such sub-delegation arrangement, Vendor must:

(a) warrant that the sub-delegation agreement between Vendor and the sub-delegated organization meets the requirements of Credentialing Authorities and all terms and provisions of this Addendum;
(b) agree to oversee and perform audits of those activities it has sub-delegated to another entity in accordance with the requirements of Credentialing Authorities and this Addendum;
(c) provide all reports to United that are required under this Addendum;
(d) not enter into the sub-delegation agreement until Vendor provides notification no less than 30 days prior.

EXHIBIT H

THIRD PARTY ADMINISTRATOR APPENDIX

[SEE ATTACHED]

THIRD PARTY ADMINISTRATOR
AND OTHER SERVICES PROVISIONS

With respect to any third party administrator ("TPA") and other services described below provided by Vendor pursuant to this Agreement, the parties shall comply with the following provisions to the extent that such provisions are applicable to the type of services being provided and in the capacity of any licenses which Vendor is required to hold. If any provision of this Addendum is deemed to be in conflict with any other provision of this Agreement, this Addendum shall control.

1. Advertising. Vendor may use only such advertising pertaining to United's business as has been approved by United in writing in advance of its use.

2. Underwriting Standards. With respect to all business underwritten by the United, Vendor shall use the underwriting and other standards, including, without limitation, criteria and procedures applicable to insurance coverage and reinsurance, if any, all as approved by United and as provided by United to Vendor from time to time.

3. Premium Collection and Payment of Claims.

    a. Any insurance charges or premiums collected by Vendor on behalf of or for United, and any return premiums received by Vendor from United, shall be held by Vendor in a fiduciary capacity.

    b. If funds deposited in a fiduciary account maintained or controlled by Vendor have been collected on behalf of or for more than one insurer, or for the payment of claims associated with more than one policy, Vendor shall keep records clearly recording the deposits in and withdrawals from such account on behalf of or for each insurer and relating to each policyholder. Vendor shall, upon request of United, furnish United with copies of such records pertaining to deposits and withdrawals of or for United, and make available to United a monthly accounting detailing all deposits into and withdrawals from the fiduciary account performed by Vendor pertaining to the business underwritten by United with any required settlement.

    c. Vendor shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Withdrawals from a fiduciary account shall be permitted only for any of the following: (i) remittance to United as United becomes entitled to such remittance, (ii) deposit in an account maintained in the name of United, (iii) transfer to and deposit in a claims-paying account, with claims to be paid in accordance with paragraph 3(d) below, (iv) payment to a group policyholder for remittance to United, (v) payment to Vendor of its compensation, fees or charges, (vi) remittance of return premium to the person or persons entitled to such return premium, and (vii) as

permitted by United.

d. All claims paid by Vendor from funds collected on behalf of United shall be paid only as authorized by United and in compliance with any unfair claims practices or other relevant statutes or regulations. Vendor shall make available to United a report of claims within 30 days. United may terminate Vendor's settlement authority for cause upon thirty (30) days prior written notice and may suspend settlement authority during any time necessary to settle any dispute over cause of termination.

e. All claims paid by Vendor from funds collected on behalf of United shall be paid only on drafts, checks or electronic transfers of and as authorized by United.

4. Delivery of Policies and Notices. Any policies, certificates, booklets, termination notices or other written communications delivered by United to Vendor for delivery to United's customers shall be delivered by Vendor promptly after receipt of instructions from United to do so.

5. Communications with Claimants. Communications between Vendor and claimants shall avoid deceptive statements with regard to the responsibilities of Vendor (as the TPA) and United with regard to claims or premiums.

6. Compensation for Adjusting or Settling Claims or Providing Utilization Review ("UR") Services. Compensation to Vendor for any policies where Vendor adjusts or settles claims and/or provides UR services shall in no way be contingent on claims experience or loss ratios in those instances where such contingency fees or other fee arrangements are prohibited by law. Compensation for UR services shall not be based on factors, including but not limited to, number or frequency or type of certification denials, reduction of services, reduction of charges, reduction of length of treatment, or utilization of alternative treatment settings to reduce amounts of necessary or appropriate medical care. Provided, however, this shall not prevent the compensation of Vendor from being based on premiums or charges collected or number of claims paid or processed. Vendor shall only be entitled to compensation for its services as expressly set forth in this Agreement.

7. Bond Required. Vendor shall maintain any and all deposits and bonds in favor of state insurance regulatory authorities that are required to be held by applicable law.

8. Payments Handled by Vendor. Whenever United utilizes such services of Vendor, any payment to Vendor of any premium or charges for insurance by or on behalf of the insured shall be deemed to have been received by United, and the payment of return premiums or claims by United to Vendor shall not be deemed payment to the insured or claimant until the payments are received by the insured or claimant. Nothing in this section shall limit any right of United against Vendor resulting from its failure to make payments to the insurer, insureds or claimants.

9. Record Keeping. In addition to other record-keeping provisions in this Agreement, Vendor shall maintain, at its principal administrative office, in accordance with prudent standards of insurance record keeping and applicable Laws and Regulations, accurate, complete and timely books and records (collectively, "Records"), of all transactions occurring as part of Administrator's furnishing of TPA Services. Any trade secrets contained in the Records, including, but not limited to, the identity and addresses of policyholders and certificate holders, shall be confidential, except that insurance regulators may use the information in any proceedings maintained against Vendor. United retains the right to continuing access to the Records of Vendor sufficient to permit United to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between United and Vendor concerning the proprietary rights of the parties in the Records.

10. Notice of Vendor's Capacity. Vendor shall provide a written notice approved by United to Members advising them of the identity of, and relationship among Vendor, the Member, and United.

11. UR Standards. The UR services performed by Vendor shall be performed in accordance with nationally recognized accreditation organization's published national standards that United is required to meet ("Utilization Review Standards") and includes, but are not limited to, the intake of information and reviewing the adequacy and appropriateness of health care services on a prospective, concurrent and retrospective basis. Vendor shall perform the UR functions in accordance with the United's requirements, policies and/or procedures, and the Utilization Review Standards.

FOURTH AMENDMENT
TO THE DENTAL SERVICES AGREEMENT

This Fourth Amendment to the Dental Services Agreement (this "Amendment"), is entered into as of July 1, 2017 (the "Amendment Effective Date") by and between Dental Benefit Providers, Inc. ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Dental Services Agreement effective January 1, 2014, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: David I. Bailey

Print Title: President

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Eric H. Johnson

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	All Dental Plans*	Dental		[redacted]	PMPM	ASO
E&I	Commercial	EHB Admin	Dental		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement

shall control, no matter if the settlement date is shorter or longer than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

FIFTH AMENDMENT
TO THE DENTAL SERVICES AGREEMENT

This Fifth Amendment to the Dental Services Agreement (this "Amendment"), is entered into as of August 1, 2018 (the "Amendment Effective Date") by and between Dental Benefit Providers, Inc. ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Dental Services Agreement effective January 1, 2014, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. The attached "Medicare Advantage Regulatory Requirements Appendix" is hereby added as Exhibit C to the Agreement. The Exhibit List is amended to add an "X" to Exhibit C: Medicare Advantage Regulatory Requirements Appendix.

4. Exhibit E, "Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix" to the Agreement is hereby deleted in its entirety and replaced with the Exhibit E, "Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix," attached hereto.

5. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: David I. Bailey

Print Title: President

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Michael J. Balcer

Print Title: Chief Financial Officer

EXHIBIT LIST

(Add X if Exhibit is attached; add N/A if there is no Exhibit:

X	Exhibit A:	Compensation for Services Addendum (Plans; Service Areas)
X	Exhibit B:	Services Addendum
X	Exhibit C:	Medicare Advantage Regulatory Requirements Appendix
N/A	Exhibit D:	HMO or Insurance Specific Requirements Appendix
X	Exhibit E:	State Regulatory Requirements Appendix
X	Exhibit F:	Delegation of Credentialing Addendum

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	All Dental Plans*	Dental	LA	[redacted]	PMPM	ASO
E&I	Commercial	EHB Admin	Dental		[redacted]	PMPM	ASO
M&R	Medicare	All Dental Plans*	Dental		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known.

Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter or longer than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

EXHIBIT C

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
MEDICAL VENDOR

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Agreement") with Dental Benefits Providers, Inc. ("Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies to the services provided by Subcontractor pursuant to the Agreement as such services relate to the provision of Covered Services to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

2.1 **Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

2.2 **CMS Contract:** A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 **Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

2.4 **Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

2.5 **Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

2.6 **Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 **Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 **Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan that is covered under the Agreement.

2.9 **Medicare Advantage Organization or MA Organization:** For purposes of this Appendix, MA Organization is: (a) UnitedHealthcare Insurance Company or one of its affiliates that has entered into a contract with CMS for the purpose of offering a Benefit Plan to MA Customers; or (b) Payer.

2.10 **Participating Provider:** A hospital, ancillary provider, physician group, individual physician, or other health care provider, duly licensed or authorized under the laws of the jurisdiction in which Covered Services are provided, who participates in MA Organization's network through a provider agreement or network participation agreement with Subcontractor.

2.11 **Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized to access Participating Providers' services rendered pursuant to the Agreement.

SECTION 3
DELEGATED ACTIVITIES

3.1 **MA Organization Accountability; Delegated Activities.** Subcontractor acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization has delegated to Subcontractor under the Agreement. In addition to the other provisions of this Appendix, the following shall apply with respect to any functions and responsibilities under the CMS Contract that MA Organization has delegated to Subcontractor pursuant to the Agreement:

(a) Subcontractor shall perform or arrange for the provision of those delegated activities set forth in the Agreement.

(b) Subcontractor shall comply with any reporting responsibilities as set forth in the Agreement.

(c) If MA Organization has delegated to Subcontractor any activities related to the credentialing of health care providers, Subcontractor must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the

credentialing process must be reviewed, preapproved, and audited on an ongoing basis by MA Organization.

(d) If MA Organization has delegated to Subcontractor the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, or the selection of contractors or subcontractors to perform services under the CMS Contract, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers and the agreements with such contractors or subcontractors.

(e) Subcontractor acknowledges that MA Organization shall monitor Subcontractor's performance of delegated activities on an ongoing basis. Such monitoring activities may include site visits and periodic audits. If CMS or MA Organization determines that Subcontractor has not performed satisfactorily, or has failed to meet all reporting and disclosure requirements in a timely manner, MA Organization may revoke any or all of the delegated activities and reporting requirements. Subcontractor shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

SECTION 4
SUBCONTRACTOR AND PARTICIPATING PROVIDER REQUIREMENTS

4.1 **Data.** Subcontractor shall and/or shall require Participating Providers to, submit to MA Organization all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Subcontractor and Participating Providers represent to MA Organization, and upon MA Organization's request, shall certify in writing, that the data is accurate, complete, and truthful, based on Subcontractor's or Participating Providers' best knowledge, information and belief.

4.2 **Policies.** Subcontractor shall, and shall require Participating Providers to, cooperate and comply with MA Organization's policies and procedures.

4.3 **Customer Protection.** Subcontractor agrees, and shall require Participating Providers to agree, that in no event, including but not limited to, non-payment by Subcontractor, MA Organization or an intermediary, insolvency of Subcontractor, MA Organization or an intermediary, or breach of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement, or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit a Participating Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit a Participating Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as

long as the Participating Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Subcontractor shall require Participating Providers to continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Subcontractor or Participating Providers and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Participating Providers or on behalf of a network through which Participating Providers elect to participate.

4.4 **Dual Eligible Customers.** Subcontractor agrees, and shall require Participating Providers to agree, that in no event, including but not limited to, non-payment by a state Medicaid Agency or other applicable regulatory authority, other state source, or breach of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Subcontractor and Participating Providers will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Subcontractor or Participating Providers impose an excess charge on a Dual Eligible Customer, Subcontractor and Participating Providers are subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit a Participating Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as the Participating Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

4.5 **Eligibility.** Subcontractor agrees and shall require Participating Providers to agree to immediately notify MA Organization in the event Subcontractor or any Participating Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Subcontractor shall not, and shall require Participating Providers not to employ or contract for the provision of health care services, utilization review, medical social work or administrative services, (collectively "Eligibility Services"), with or without compensation, with any individual or entity that is or becomes excluded from participation in any

federal or state health care program under Section 1128 or 1128A of the Social Security Act. Subcontractor shall and shall require Participating Providers to review the Department of Health and Human Services Officer of Inspector General List of Excluded Individuals and Entities and the System for Award Management (SAM), a portal for the Federal Procurement System (or any successor listing of excluded individuals or entities) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member or subcontractor for the provision of Eligibility Services. Subcontractor must and must require Participating Providers to continue to review these lists on a monthly basis thereafter to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

4.6 **Laws.** Subcontractor shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.7 **Federal Funds.** Subcontractor acknowledges, and agrees to inform Participating Providers, that MA Organization receives federal payments under the CMS Contract and that payments Subcontractor or Participating Providers receive from or on behalf of MA Organization are, in whole or in part, from federal funds. Subcontractor and Participating Providers are therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

4.8 **CMS Contract.** Subcontractor shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract. Subcontractor shall also require that health care services rendered to MA Customers by Participating Providers pursuant to the Agreement are performed in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

4.9 **Records.**

(a) Maintenance; Privacy and Confidentiality; Customer Access. Subcontractor shall maintain records and information related to services provided by Subcontractor under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Subcontractor shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

Subcontractor shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, including the requirements established by MA Organization and the Medicare Advantage program, as applicable. Subcontractor shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law. Subcontractor shall require Participating Providers to comply with all the requirements in this section with respect to records and information related to health care services provided by Participating Providers to MA Customers pursuant to the Agreement.

(b) Government Access to Records. Subcontractor acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, computer or other electronic systems (including medical records), patient care documentation and other records and information belonging to Subcontractor and Participating Providers that involve transactions related to the CMS Contract. This right shall extend through the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations.

For the purpose of conducting the above activities, Subcontractor shall, and shall require Participating Providers to, make available their premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

(c) MA Organization Access to Records. Subcontractor shall, and shall require Participating Providers to, grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 4.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Subcontractor and Participating Providers reasonable notice of the

need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Subcontractor shall, and shall require Participating Providers to, submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

4.10 **Subcontracts.** If Subcontractor has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries or any other subcontractors, directly or through another person or entity, to perform any of the services Subcontractor is obligated to perform under the Agreement that are the subject of this Appendix, Subcontractor shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Subcontractor shall provide proof of such to MA Organization upon request. In addition, Subcontractor agrees to oversee and monitor, on an ongoing basis, the services Subcontractor has subcontracted to another person or entity. Subcontractor further agrees to promptly amend its agreements with such subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization, to meet any additional CMS requirements that may apply to the services. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.11 **Offshoring.** Unless previously authorized by MA Organization in writing, all services provided by Subcontractor pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories. The following provisions apply to Medicare-related services that involve Medicare beneficiary protected health information ("PHI") performed pursuant to the Agreement at locations outside of one of the fifty United Sates, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands):

(a) Subcontractor represents and warrants to MA Organization that Subcontractor has in place and will comply with policies and procedures to ensure that all PHI and other personal information remains secure. Subcontractor will provide written evidence of the policies and procedures upon MA Organization's request.

(b) Subcontractor will provide prior written notice to MA Organization of (a) any material change in the Medicare-related services that involve PHI that Subcontractor performs offshore, (b) any material change in Subcontractor's policies and procedures to ensure that all PHI and other personal information remains secure, and (c) any material change in the tools and systems used by Subcontractor to ensure that all PHI and other personal information remains secure.

(c) Subcontractor is prohibited from receiving access to any PHI or other personal information of MA Customers that is not associated with services performed and products provided by Subcontractor pursuant to the Agreement. If Subcontractor receives access to PHI or other personal information of MA Customers that is not associated with

Subcontractor's services performed and products provided by Subcontractor pursuant to the Agreement, Subcontractor will immediately notify MA Organization that it has received such access, return all PHI or personal information accessed by Subcontractor, and destroy any such PHI or personal information that remains in Subcontractor's possession after doing so (i.e. copies, electronic records, back-ups or temporary files).

(d) Subcontractor's services under the Agreement may be terminated immediately upon discovery of a significant security breach.

(e) Subcontractor authorizes MA Organization or its designee to conduct an audit of Subcontractor at least annually.

(f) Subcontractor acknowledges and agrees that MA Organization will use the results of its audit of Subcontractor to evaluate the continuation of MA Organization's relationship with Subcontractor.

(g) Subcontractor authorizes MA Organization or its designee to share the results of audits of Subcontractor with CMS.

SECTION 5
OTHER

5.1 **Payment.** MA Organization or its designee shall promptly process and pay or deny a Participating Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Subcontractor or Participating Providers are responsible for making payment to subcontracted providers for services provided to MA Customers, Subcontractor shall, and shall require Participating Providers to, pay such providers no later than sixty (60) days after Subcontractor or a Participating Provider receives request for payment for those services from subcontracted providers.

5.2 **Regulatory Amendment.** MA Organization may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. MA Organization shall provide written notice to Subcontractor of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Subcontractor will not be required in order for the amendment to take effect.

EXHIBIT E

LOUISIANA MEDICAID AND CHIP PROGRAM
REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Subcontract") between UnitedHealthcare of Louisiana, Inc. ("United") and subcontractor named in the agreement to which this Appendix is attached (the "Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the Louisiana Healthy Louisiana and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Agreement:** An executed contract between Subcontractor and a Provider for the provision of Covered Services to persons enrolled in the State Program(s).

2.2 **Covered Person(s):** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement and/or Subcontract.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or LDH:** The Louisiana Department of Health.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement with Subcontractor for the provision of Covered Services to Covered Persons.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract(s) with LDH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Healthy Louisiana and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Covered Services; Definitions Related to Coverage. Provider shall follow the State Contract's requirements for the provision of Covered Services. A description of the package of benefits offered by LDH under the State Program is available on the LDH website at http://www.makingmedicaidbetter.com/. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be based on the individual's medical needs and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR Part 438.114(a) and § 1932(b)(2) of the Social Security Act of 1935 (42 U.S.C. § 1396u-2) and that are needed to screen, evaluate, and stabilize an Emergency

Medical Condition. Emergency Services also include services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). There are no prior authorization requirements for Emergency Services.

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial or non-Medicaid/CHIP members or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

3.3 Antitrust. Provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any State Program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Louisiana Health. For purposes of this assignment clause, "Provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's

relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. Subcontractor and Provider shall accept the final payment made by United as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the Covered Persons(s). Covered Person shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. At all times during the Agreement, Subcontractor shall, and shall ensure Provider indemnifies, defends, protects, and holds harmless LDH and any of its officers, agents, and employees from:

(a) Any claims, losses, or suits relating to activities undertaken by Subcontractor and/or Provider pursuant to the Agreement or pursuant to the State Contract;

(b) Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for Subcontractor and/or Provider in connection with performance of the Agreement or in connection with performance of the State Contract;

(c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Provider and/or Subcontractor, its agents, officers, employees, or contractors in performance of the Agreement or in performance of the State Contract;

(d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor and/or Provider, its agents, officers, employees, or contractors, by Subcontractor's and/or Provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the State Contract, or by federal or State regulations or statutes;

(e) Any failure of Subcontractor and/or Provider, its agents, officers, employees, or contractors, to observe federal or State laws, including but not limited to labor laws and minimum wage laws;

(f) Any claims for damages, losses, or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

(g) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against LDH or its agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor and/or Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of United, Subcontractor, Provider, or LDH (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), United, Subcontractor, Provider, or LDH will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the State Contract remains in full force and effect, United shall be liable for authorizing services required in accordance with the State Contract.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records, to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, LDH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Retention. Subcontractor shall, and shall require Provider to retain all administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by LDH (whether paper or electronic) for the later of: (i) ten (10) years from the expiration date of the State Contract, including any extension(s) thereof; or (ii) for Covered Person records, for ten (10) years after the last payment was made for services provided to the Covered Person (an exception to this requirement includes records pertaining to once in a lifetime events, including but not limited to appendectomy and amputations, etc., which must be retained indefinitely and may not be destroyed); or (iii) such other period as required by law. Notwithstanding the foregoing, if the records are under review or audit or related to any matter in litigation, such records shall be retained until completion of the audit, review or litigation and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

The above record retention requirements pertain to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least ten (10) years, commencing from the last date of treatment.

(d) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to LDH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Inspection, Audit and Evaluation

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana

Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as often as they may deem necessary during the State Contract period and for a period of ten (10) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

(b) By LDH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of LDH.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require that Provider understand that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Subcontractor will require that Provider further acknowledge that, in some cases, Provider will have access to information on individuals with whom Provider has no treatment or other relationship. In such cases Provider will abide by all requirements under HIPAA and ensure that the confidentiality of such information is fully maintained.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with the Agreement and Subcontract, including the U.S. Department of Health and Human

Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Subcontractor shall, and shall require Provider to notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract and LDH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract and LDH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and LDH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the LDH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and

nondiscrimination. If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's and/or Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.11 Excluded Individuals. By signing the Agreement, Subcontractor certifies, and shall require Provider to certify to the best of Subcontractor's and Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under either § 1128 or § 1128A of the Social Security Act;

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. United will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

4.12 Cultural Competency. Subcontractor shall, and shall require Providers to deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 § CFR 438.206(c)(2). Subcontractor shall and shall require Providers to ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Subcontractor shall, and shall require Provider to take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Agreement must be submitted to United to submit to the Department for prior approval. In addition, Subcontractor shall, and shall require Provider to comply with the State Contract's requirements related to marketing communications.

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist LDH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network,

employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA)
Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Outstanding Claim Information. In the event of termination of the Agreement, Subcontractor shall, and shall require Provider to promptly supply to United or its designee all information necessary for the reimbursement of any outstanding Medicaid claims.

4.16 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.17 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in LDH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information.

4.18 Quality Assessment/Utilization Management Review. Subcontractor shall, and shall require Provider to adhere to the State Program's Quality Assessment and Performance Improvement (QAPI) program requirements, as outlined in the State Contract and the Quality Companion Guide, which are incorporated herein by reference and shall be furnished to Subcontractor and/or Provider upon request. Subcontractor shall, and shall require Provider to cooperate with United's QAPI and utilization management (UM) programs, which adhere to all LDH QAPI and UM program requirements. Subcontractor agrees, and shall require Provider to agree to participate and cooperate in any internal or external quality assessment review, utilization management, or grievance procedures established by United and/or the Department or its designee, whether such review or procedures are announced or unannounced.

4.19 Insurance. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. LDH and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider.

4.20 Licensing Requirements. Subcontractor represents, and shall require that Provider represent that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate Louisiana licensing body or standard-setting agency, as applicable. Subcontractor represents, and shall require that Provider represent that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Subcontractor represents, and shall require Provider to represent that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the Office of the Louisiana Attorney General. Subcontractor shall, and shall require Provider to maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Subcontractor and Provider by United under the Agreement. If at any time during the term of the Agreement, Subcontractor and/or Provider are not properly licensed as described in this Section, Subcontractor shall, and shall require Provider to discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

4.21 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.22 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United.

4.23 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.24 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.25 Data and Reports. Subcontractor shall, and shall ensure Provider submits to United all reports and clinical information which United or LDH may require for reporting purposes pursuant to the State Contract, including but not limited to encounter data, HEDIS, AHRQ and EPSDT data and reports, where applicable. Provider shall utilize LDH's Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations. As applicable, if United has entered into alternative reimbursement arrangements with Subcontractor and/or Provider (with prior approval by the Department), Subcontractor and Provider are required to submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by United. NOTE: United is not allowed to enter into alternative reimbursement arrangements with FQHCs or RHCs.

4.26 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or LDH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

If Provider discovers an error or a conflict with a previously adjudicated encounter claim, Subcontractor and/or Health Plan shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or if circumstances exist that prevent Subcontractor and/or Health Plan from meeting this time frame a specified date shall be approved by LDH.

When Subcontractor has entered into an alternative reimbursement arrangement with Provider, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the Subcontractor.

4.27 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.28 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by LDH.

4.29 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the

services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the scope of Subcontractor's and/or Provider's practice.

4.30 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.31 Appeals and Grievances. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with LDH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have correct and adequate supply of such public notices.

4.32 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH has the right to direct United to impose financial consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

4.33 Primary Care Provider ("PCP") Linkages. If Provider is a PCP, Subcontractor shall require Provider to stipulate by signing an agreement that Provider's total number of Medicaid/CHIP members for the State Program will not exceed 2,500 lives per full-time physician or 1,000 lives per mid-level practitioner or physician extender up to a cap of 2,500 lives. Prior to executing an Agreement, Subcontractor, Provider and United shall specify the number of linkages United may link to Provider.

4.34 Birth Registration. As applicable, Subcontractor shall ensure Provider registers all births through LEERS (Louisiana Electronic Event Registration System) administered by the LDH/Vital Records Registry. Hospital Providers must notify United and LDH of the birth of a newborn when the mother is a member of United, complete the web-based LDH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to LDH.

4.35 Laboratory Services. If Provider performs laboratory services, Subcontractor shall ensure Provider meets all applicable State and federal requirements, including but not limited to 42 CFR

Sections 493.1 and 493.3, as may be amended from time to time. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Subcontractor shall require that Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Subcontractor shall further ensure Provider provides a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

4.36 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall ensure Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Agreement. Subcontractor understands, and shall ensure Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.37 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

4.38 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

4.39 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

4.40 Advance Directives. Subcontractor shall, and shall ensure Provider complies with the advance directives requirements for hospitals, nursing facilities, providers of home and health

care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

4.41 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

4.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and applicants.

4.43 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

4.44 Healthcare Oversight Agency Compliance. Subcontractor shall, and shall require Providers to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities that manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but do not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and United, Subcontractor or Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. United, Subcontractor and/or Provider agree that the State Contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

SECTION 5
UNITED REQUIREMENTS

5.1 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6

OTHER REQUIREMENTS

6.1 State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any requirement or provision of the Agreement or this Appendix is determined by LDH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Agreement and this Appendix shall remain in full force and effect.

6.2 Ongoing Monitoring. As required under the State Contract, United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Agreement and shall perform periodic formal reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or LDH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established by LDH in the State Contract and LDH-issued guides.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of LDH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and LDH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that LDH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the State Contract. United will submit and obtain prior approval from LDH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of LDH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 Health Care-Acquired/Preventable Conditions. United and Subcontractor acknowledge and agree that United is prohibited from making payments to Subcontractor for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by LDH.

6.10 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.11 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by LDH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The

date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

6.12 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.13 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that

it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.16 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

EXHIBIT LIST

(Add X if Exhibit is attached; add N/A if there is no Exhibit:

X	Exhibit A:	Compensation for Services Addendum (Plans; Service Areas)
X	Exhibit B:	Services Addendum
X	Exhibit C:	Medicare Advantage Regulatory Requirements Appendix
N/A	Exhibit D:	HMO or Insurance Specific Requirements Appendix
X	Exhibit E:	State Regulatory Requirements Appendix
X	Exhibit F:	Delegation of Credentialing Addendum

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	All Dental Plans*	Dental	LA	[redacted]	PMPM	ASO
E&I	Commercial	EHB Admin	Dental		[redacted]	PMPM	ASO
M&R	Medicare	All Dental Plans*	Dental		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known.

Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter or longer than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

EXHIBIT C

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
MEDICAL VENDOR

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Agreement") with Dental Benefits Providers, Inc. ("Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies to the services provided by Subcontractor pursuant to the Agreement as such services relate to the provision of Covered Services to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

2.1 **Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

2.2 **CMS Contract:** A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 **Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

2.4 **Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

2.5 **Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

2.6 **Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 **Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 **Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan that is covered under the Agreement.

2.9 **Medicare Advantage Organization or MA Organization:** For purposes of this Appendix, MA Organization is: (a) UnitedHealthcare Insurance Company or one of its affiliates that has entered into a contract with CMS for the purpose of offering a Benefit Plan to MA Customers; or (b) Payer.

2.10 **Participating Provider:** A hospital, ancillary provider, physician group, individual physician, or other health care provider, duly licensed or authorized under the laws of the jurisdiction in which Covered Services are provided, who participates in MA Organization's network through a provider agreement or network participation agreement with Subcontractor.

2.11 **Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized to access Participating Providers' services rendered pursuant to the Agreement.

SECTION 3
DELEGATED ACTIVITIES

3.1 **MA Organization Accountability; Delegated Activities.** Subcontractor acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization has delegated to Subcontractor under the Agreement. In addition to the other provisions of this Appendix, the following shall apply with respect to any functions and responsibilities under the CMS Contract that MA Organization has delegated to Subcontractor pursuant to the Agreement:

(a) Subcontractor shall perform or arrange for the provision of those delegated activities set forth in the Agreement.

(b) Subcontractor shall comply with any reporting responsibilities as set forth in the Agreement.

(c) If MA Organization has delegated to Subcontractor any activities related to the credentialing of health care providers, Subcontractor must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the

credentialing process must be reviewed, preapproved, and audited on an ongoing basis by MA Organization.

(d) If MA Organization has delegated to Subcontractor the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, or the selection of contractors or subcontractors to perform services under the CMS Contract, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers and the agreements with such contractors or subcontractors.

(e) Subcontractor acknowledges that MA Organization shall monitor Subcontractor's performance of delegated activities on an ongoing basis. Such monitoring activities may include site visits and periodic audits. If CMS or MA Organization determines that Subcontractor has not performed satisfactorily, or has failed to meet all reporting and disclosure requirements in a timely manner, MA Organization may revoke any or all of the delegated activities and reporting requirements. Subcontractor shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

SECTION 4
SUBCONTRACTOR AND PARTICIPATING PROVIDER REQUIREMENTS

4.1 **Data.** Subcontractor shall and/or shall require Participating Providers to, submit to MA Organization all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Subcontractor and Participating Providers represent to MA Organization, and upon MA Organization's request, shall certify in writing, that the data is accurate, complete, and truthful, based on Subcontractor's or Participating Providers' best knowledge, information and belief.

4.2 **Policies.** Subcontractor shall, and shall require Participating Providers to, cooperate and comply with MA Organization's policies and procedures.

4.3 **Customer Protection.** Subcontractor agrees, and shall require Participating Providers to agree, that in no event, including but not limited to, non-payment by Subcontractor, MA Organization or an intermediary, insolvency of Subcontractor, MA Organization or an intermediary, or breach of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement, or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit a Participating Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit a Participating Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as

long as the Participating Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Subcontractor shall require Participating Providers to continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Subcontractor or Participating Providers and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Participating Providers or on behalf of a network through which Participating Providers elect to participate.

4.4 **Dual Eligible Customers.** Subcontractor agrees, and shall require Participating Providers to agree, that in no event, including but not limited to, non-payment by a state Medicaid Agency or other applicable regulatory authority, other state source, or breach of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Subcontractor and Participating Providers will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Subcontractor or Participating Providers impose an excess charge on a Dual Eligible Customer, Subcontractor and Participating Providers are subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit a Participating Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as the Participating Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

4.5 **Eligibility.** Subcontractor agrees and shall require Participating Providers to agree to immediately notify MA Organization in the event Subcontractor or any Participating Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Subcontractor shall not, and shall require Participating Providers not to employ or contract for the provision of health care services, utilization review, medical social work or administrative services, (collectively "Eligibility Services"), with or without compensation, with any individual or entity that is or becomes excluded from participation in any

federal or state health care program under Section 1128 or 1128A of the Social Security Act. Subcontractor shall and shall require Participating Providers to review the Department of Health and Human Services Officer of Inspector General List of Excluded Individuals and Entities and the System for Award Management (SAM), a portal for the Federal Procurement System (or any successor listing of excluded individuals or entities) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member or subcontractor for the provision of Eligibility Services. Subcontractor must and must require Participating Providers to continue to review these lists on a monthly basis thereafter to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

4.6 **Laws.** Subcontractor shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.7 **Federal Funds.** Subcontractor acknowledges, and agrees to inform Participating Providers, that MA Organization receives federal payments under the CMS Contract and that payments Subcontractor or Participating Providers receive from or on behalf of MA Organization are, in whole or in part, from federal funds. Subcontractor and Participating Providers are therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

4.8 **CMS Contract.** Subcontractor shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract. Subcontractor shall also require that health care services rendered to MA Customers by Participating Providers pursuant to the Agreement are performed in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

4.9 **Records.**

(a) Maintenance; Privacy and Confidentiality; Customer Access. Subcontractor shall maintain records and information related to services provided by Subcontractor under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Subcontractor shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

Subcontractor shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, including the requirements established by MA Organization and the Medicare Advantage program, as applicable. Subcontractor shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law. Subcontractor shall require Participating Providers to comply with all the requirements in this section with respect to records and information related to health care services provided by Participating Providers to MA Customers pursuant to the Agreement.

(b) Government Access to Records. Subcontractor acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, computer or other electronic systems (including medical records), patient care documentation and other records and information belonging to Subcontractor and Participating Providers that involve transactions related to the CMS Contract. This right shall extend through the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations.

For the purpose of conducting the above activities, Subcontractor shall, and shall require Participating Providers to, make available their premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

(c) MA Organization Access to Records. Subcontractor shall, and shall require Participating Providers to, grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 4.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Subcontractor and Participating Providers reasonable notice of the

need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Subcontractor shall, and shall require Participating Providers to, submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

4.10 **Subcontracts.** If Subcontractor has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries or any other subcontractors, directly or through another person or entity, to perform any of the services Subcontractor is obligated to perform under the Agreement that are the subject of this Appendix, Subcontractor shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Subcontractor shall provide proof of such to MA Organization upon request. In addition, Subcontractor agrees to oversee and monitor, on an ongoing basis, the services Subcontractor has subcontracted to another person or entity. Subcontractor further agrees to promptly amend its agreements with such subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization, to meet any additional CMS requirements that may apply to the services. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.11 **Offshoring.** Unless previously authorized by MA Organization in writing, all services provided by Subcontractor pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories. The following provisions apply to Medicare-related services that involve Medicare beneficiary protected health information ("PHI") performed pursuant to the Agreement at locations outside of one of the fifty United Sates, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands):

(a) Subcontractor represents and warrants to MA Organization that Subcontractor has in place and will comply with policies and procedures to ensure that all PHI and other personal information remains secure. Subcontractor will provide written evidence of the policies and procedures upon MA Organization's request.

(b) Subcontractor will provide prior written notice to MA Organization of (a) any material change in the Medicare-related services that involve PHI that Subcontractor performs offshore, (b) any material change in Subcontractor's policies and procedures to ensure that all PHI and other personal information remains secure, and (c) any material change in the tools and systems used by Subcontractor to ensure that all PHI and other personal information remains secure.

(c) Subcontractor is prohibited from receiving access to any PHI or other personal information of MA Customers that is not associated with services performed and products provided by Subcontractor pursuant to the Agreement. If Subcontractor receives access to PHI or other personal information of MA Customers that is not associated with

Subcontractor's services performed and products provided by Subcontractor pursuant to the Agreement, Subcontractor will immediately notify MA Organization that it has received such access, return all PHI or personal information accessed by Subcontractor, and destroy any such PHI or personal information that remains in Subcontractor's possession after doing so (i.e. copies, electronic records, back-ups or temporary files).

(d) Subcontractor's services under the Agreement may be terminated immediately upon discovery of a significant security breach.

(e) Subcontractor authorizes MA Organization or its designee to conduct an audit of Subcontractor at least annually.

(f) Subcontractor acknowledges and agrees that MA Organization will use the results of its audit of Subcontractor to evaluate the continuation of MA Organization's relationship with Subcontractor.

(g) Subcontractor authorizes MA Organization or its designee to share the results of audits of Subcontractor with CMS.

SECTION 5
OTHER

5.1 **Payment.** MA Organization or its designee shall promptly process and pay or deny a Participating Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Subcontractor or Participating Providers are responsible for making payment to subcontracted providers for services provided to MA Customers, Subcontractor shall, and shall require Participating Providers to, pay such providers no later than sixty (60) days after Subcontractor or a Participating Provider receives request for payment for those services from subcontracted providers.

5.2 **Regulatory Amendment.** MA Organization may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. MA Organization shall provide written notice to Subcontractor of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Subcontractor will not be required in order for the amendment to take effect.

EXHIBIT E

LOUISIANA MEDICAID AND CHIP PROGRAM
REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Subcontract") between UnitedHealthcare of Louisiana, Inc. ("United") and subcontractor named in the agreement to which this Appendix is attached (the "Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the Louisiana Healthy Louisiana and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Agreement:** An executed contract between Subcontractor and a Provider for the provision of Covered Services to persons enrolled in the State Program(s).

2.2 **Covered Person(s):** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement and/or Subcontract.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or LDH:** The Louisiana Department of Health.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement with Subcontractor for the provision of Covered Services to Covered Persons.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract(s) with LDH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Healthy Louisiana and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Covered Services; Definitions Related to Coverage. Provider shall follow the State Contract's requirements for the provision of Covered Services. A description of the package of benefits offered by LDH under the State Program is available on the LDH website at http://www.makingmedicaidbetter.com/. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be based on the individual's medical needs and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR Part 438.114(a) and § 1932(b)(2) of the Social Security Act of 1935 (42 U.S.C. § 1396u-2) and that are needed to screen, evaluate, and stabilize an Emergency

Medical Condition. Emergency Services also include services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). There are no prior authorization requirements for Emergency Services.

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial or non-Medicaid/CHIP members or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

3.3 Antitrust. Provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any State Program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Louisiana Health. For purposes of this assignment clause, "Provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's

relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. Subcontractor and Provider shall accept the final payment made by United as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the Covered Persons(s). Covered Person shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. At all times during the Agreement, Subcontractor shall, and shall ensure Provider indemnifies, defends, protects, and holds harmless LDH and any of its officers, agents, and employees from:

(a) Any claims, losses, or suits relating to activities undertaken by Subcontractor and/or Provider pursuant to the Agreement or pursuant to the State Contract;

(b) Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for Subcontractor and/or Provider in connection with performance of the Agreement or in connection with performance of the State Contract;

(c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Provider and/or Subcontractor, its agents, officers, employees, or contractors in performance of the Agreement or in performance of the State Contract;

(d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor and/or Provider, its agents, officers, employees, or contractors, by Subcontractor's and/or Provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the State Contract, or by federal or State regulations or statutes;

(e) Any failure of Subcontractor and/or Provider, its agents, officers, employees, or contractors, to observe federal or State laws, including but not limited to labor laws and minimum wage laws;

(f) Any claims for damages, losses, or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

(g) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against LDH or its agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor and/or Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of United, Subcontractor, Provider, or LDH (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), United, Subcontractor, Provider, or LDH will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the State Contract remains in full force and effect, United shall be liable for authorizing services required in accordance with the State Contract.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records, to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, LDH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Retention. Subcontractor shall, and shall require Provider to retain all administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by LDH (whether paper or electronic) for the later of: (i) ten (10) years from the expiration date of the State Contract, including any extension(s) thereof; or (ii) for Covered Person records, for ten (10) years after the last payment was made for services provided to the Covered Person (an exception to this requirement includes records pertaining to once in a lifetime events, including but not limited to appendectomy and amputations, etc., which must be retained indefinitely and may not be destroyed); or (iii) such other period as required by law. Notwithstanding the foregoing, if the records are under review or audit or related to any matter in litigation, such records shall be retained until completion of the audit, review or litigation and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

The above record retention requirements pertain to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least ten (10) years, commencing from the last date of treatment.

(d) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to LDH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Inspection, Audit and Evaluation

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana

Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as often as they may deem necessary during the State Contract period and for a period of ten (10) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

(b) By LDH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of LDH.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require that Provider understand that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Subcontractor will require that Provider further acknowledge that, in some cases, Provider will have access to information on individuals with whom Provider has no treatment or other relationship. In such cases Provider will abide by all requirements under HIPAA and ensure that the confidentiality of such information is fully maintained.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with the Agreement and Subcontract, including the U.S. Department of Health and Human

Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Subcontractor shall, and shall require Provider to notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract and LDH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract and LDH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and LDH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the LDH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and

nondiscrimination. If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's and/or Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.11 Excluded Individuals. By signing the Agreement, Subcontractor certifies, and shall require Provider to certify to the best of Subcontractor's and Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under either § 1128 or § 1128A of the Social Security Act;

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. United will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

4.12 Cultural Competency. Subcontractor shall, and shall require Providers to deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 § CFR 438.206(c)(2). Subcontractor shall and shall require Providers to ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Subcontractor shall, and shall require Provider to take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Agreement must be submitted to United to submit to the Department for prior approval. In addition, Subcontractor shall, and shall require Provider to comply with the State Contract's requirements related to marketing communications.

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist LDH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network,

employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA)
Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Outstanding Claim Information. In the event of termination of the Agreement, Subcontractor shall, and shall require Provider to promptly supply to United or its designee all information necessary for the reimbursement of any outstanding Medicaid claims.

4.16 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.17 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in LDH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information.

4.18 Quality Assessment/Utilization Management Review. Subcontractor shall, and shall require Provider to adhere to the State Program's Quality Assessment and Performance Improvement (QAPI) program requirements, as outlined in the State Contract and the Quality Companion Guide, which are incorporated herein by reference and shall be furnished to Subcontractor and/or Provider upon request. Subcontractor shall, and shall require Provider to cooperate with United's QAPI and utilization management (UM) programs, which adhere to all LDH QAPI and UM program requirements. Subcontractor agrees, and shall require Provider to agree to participate and cooperate in any internal or external quality assessment review, utilization management, or grievance procedures established by United and/or the Department or its designee, whether such review or procedures are announced or unannounced.

4.19 Insurance. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. LDH and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider.

4.20 Licensing Requirements. Subcontractor represents, and shall require that Provider represent that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate Louisiana licensing body or standard-setting agency, as applicable. Subcontractor represents, and shall require that Provider represent that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Subcontractor represents, and shall require Provider to represent that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the Office of the Louisiana Attorney General. Subcontractor shall, and shall require Provider to maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Subcontractor and Provider by United under the Agreement. If at any time during the term of the Agreement, Subcontractor and/or Provider are not properly licensed as described in this Section, Subcontractor shall, and shall require Provider to discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

4.21 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.22 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United.

4.23 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.24 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.25 Data and Reports. Subcontractor shall, and shall ensure Provider submits to United all reports and clinical information which United or LDH may require for reporting purposes pursuant to the State Contract, including but not limited to encounter data, HEDIS, AHRQ and EPSDT data and reports, where applicable. Provider shall utilize LDH's Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations. As applicable, if United has entered into alternative reimbursement arrangements with Subcontractor and/or Provider (with prior approval by the Department), Subcontractor and Provider are required to submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by United. NOTE: United is not allowed to enter into alternative reimbursement arrangements with FQHCs or RHCs.

4.26 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or LDH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

If Provider discovers an error or a conflict with a previously adjudicated encounter claim, Subcontractor and/or Health Plan shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or if circumstances exist that prevent Subcontractor and/or Health Plan from meeting this time frame a specified date shall be approved by LDH.

When Subcontractor has entered into an alternative reimbursement arrangement with Provider, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the Subcontractor.

4.27 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.28 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by LDH.

4.29 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the

services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the scope of Subcontractor's and/or Provider's practice.

4.30 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.31 Appeals and Grievances. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with LDH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have correct and adequate supply of such public notices.

4.32 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH has the right to direct United to impose financial consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

4.33 Primary Care Provider ("PCP") Linkages. If Provider is a PCP, Subcontractor shall require Provider to stipulate by signing an agreement that Provider's total number of Medicaid/CHIP members for the State Program will not exceed 2,500 lives per full-time physician or 1,000 lives per mid-level practitioner or physician extender up to a cap of 2,500 lives. Prior to executing an Agreement, Subcontractor, Provider and United shall specify the number of linkages United may link to Provider.

4.34 Birth Registration. As applicable, Subcontractor shall ensure Provider registers all births through LEERS (Louisiana Electronic Event Registration System) administered by the LDH/Vital Records Registry. Hospital Providers must notify United and LDH of the birth of a newborn when the mother is a member of United, complete the web-based LDH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to LDH.

4.35 Laboratory Services. If Provider performs laboratory services, Subcontractor shall ensure Provider meets all applicable State and federal requirements, including but not limited to 42 CFR

Sections 493.1 and 493.3, as may be amended from time to time. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Subcontractor shall require that Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Subcontractor shall further ensure Provider provides a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

4.36 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall ensure Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Agreement. Subcontractor understands, and shall ensure Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.37 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

4.38 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

4.39 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

4.40 Advance Directives. Subcontractor shall, and shall ensure Provider complies with the advance directives requirements for hospitals, nursing facilities, providers of home and health

care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

4.41 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

4.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and applicants.

4.43 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

4.44 Healthcare Oversight Agency Compliance. Subcontractor shall, and shall require Providers to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities that manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but do not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and United, Subcontractor or Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. United, Subcontractor and/or Provider agree that the State Contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

SECTION 5
UNITED REQUIREMENTS

5.1 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6

OTHER REQUIREMENTS

6.1 State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any requirement or provision of the Agreement or this Appendix is determined by LDH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Agreement and this Appendix shall remain in full force and effect.

6.2 Ongoing Monitoring. As required under the State Contract, United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Agreement and shall perform periodic formal reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or LDH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established by LDH in the State Contract and LDH-issued guides.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of LDH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and LDH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that LDH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the State Contract. United will submit and obtain prior approval from LDH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of LDH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 Health Care-Acquired/Preventable Conditions. United and Subcontractor acknowledge and agree that United is prohibited from making payments to Subcontractor for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by LDH.

6.10 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.11 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by LDH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The

date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

6.12 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.13 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that

it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.16 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

SIXTH AMENDMENT
TO THE DENTAL SERVICES AGREEMENT

This Sixth Amendment to the Dental Services Agreement (this "Amendment"), is entered into as of July 1, 2019 (the "Amendment Effective Date") by and between Dental Benefit Providers, Inc. ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Dental Services Agreement effective January 1, 2014, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Exhibit C, "Medicare Advantage Regulatory Requirements Appendix" to the Agreement is hereby deleted in its entirety and replaced with the Exhibit C attached hereto.

4. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[*REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: _____

Print Name: Michael C. Brody

Print Title: Assistant Secretary

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: _____

Print Name: Michael J. Balcer

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicaid	All Dental Plans*	Dental		[redacted]	PMPM	ASO
E&I	Commercial	EHB Admin	Dental		[redacted]	PMPM	ASO
M&R	Medicare	All Dental Plans*	Dental		[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

EXHIBIT C

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
MEDICAL VENDOR

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX ("Appendix") supplements and is made part of the agreement ("Agreement") with Dental Benefit Providers, Inc. ("Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies to the services provided by Subcontractor pursuant to the Agreement as such services relate to the provision of Covered Services to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

2.1 Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

2.2 CMS Contract: A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 Cost Sharing: Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

2.4 Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

2.5 Customer: A person eligible and enrolled to receive coverage from a Payer for Covered Services.

2.6 Dual Eligible Customer: A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 Medicare Advantage Customer or MA Customer: A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan that is covered under the Agreement.

2.9 Medicare Advantage Organization or MA Organization: For purposes of this Appendix, MA Organization is: (a) UnitedHealthcare Insurance Company and/or one or more of its affiliates ("United") that has entered into a contract with CMS for the purpose of offering a Benefit Plan to MA Customers; or (b) Payer.

2.10 Participating Provider: A hospital, ancillary provider, physician group, individual physician, or other health care provider, duly licensed or authorized under the laws of the jurisdiction in which Covered Services are provided, who participates in MA Organization's network through a provider agreement or network participation agreement with Subcontractor.

2.11 Payer: An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized to access Participating Providers' services rendered pursuant to the Agreement.

SECTION 3
DELEGATED ACTIVITIES

3.1 MA Organization Accountability; Delegated Activities. Subcontractor acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization has delegated to Subcontractor under the Agreement. In addition to the other provisions of this Appendix, the following shall apply with respect to any functions and responsibilities under the CMS Contract that MA Organization has delegated to Subcontractor pursuant to the Agreement:

(a) Subcontractor shall perform or arrange for the provision of those delegated activities set forth in the Agreement.

(b) Subcontractor shall comply with any reporting responsibilities as set forth in the Agreement.

(c) If MA Organization has delegated to Subcontractor any activities related to the credentialing of health care providers, Subcontractor must comply with all applicable CMS requirements for credentialing including, but not limited to, the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the credentialing process must be reviewed, preapproved, and audited on an ongoing basis by MA Organization.

(d) If MA Organization has delegated to Subcontractor the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, or the selection of contractors or subcontractors to perform services under the CMS Contract, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers and the agreements with such contractors or subcontractors.

(e) Subcontractor acknowledges that MA Organization shall monitor Subcontractor's performance of delegated activities on an ongoing basis. Such monitoring activities may include site visits and periodic audits. If CMS or MA Organization determines that Subcontractor has not performed satisfactorily, or has failed to meet all reporting and disclosure requirements in a timely manner, MA Organization may revoke any or all of the delegated activities and reporting requirements. Subcontractor shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

SECTION 4
SUBCONTRACTOR AND PARTICIPATING PROVIDER REQUIREMENTS

4.1 Data. Subcontractor shall and/or shall require Participating Providers to, submit to MA Organization all risk adjustment data as defined in 42 CFR § 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Subcontractor and Participating Providers represent to MA Organization, and upon MA Organization's request, shall certify in writing, that the data is accurate, complete, and truthful, based on Subcontractor's or Participating Providers' best knowledge, information and belief.

4.2 Policies. Subcontractor shall, and shall require Participating Providers to, comply with MA Organization's policies and procedures.

4.3 Customer Protection. Subcontractor agrees, and shall require Participating Providers to agree, that in no event including, but not limited to, non-payment by Subcontractor, MA Organization or an intermediary, insolvency of Subcontractor, MA Organization or an intermediary, or breach by United of the

Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Participating Providers or on behalf of a network through which Participating Providers elect to participate. In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Subcontractor shall require Participating Providers to continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

4.4 Dual Eligible Customers. Subcontractor agrees, and shall require Participating Providers to agree, that in no event including, but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by United of the Agreement, shall Subcontractor or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Subcontractor and Participating Providers will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Subcontractor or Participating Providers impose an excess charge on a Dual Eligible Customer, Subcontractor and Participating Providers are subject to any lawful sanction that may be imposed under Medicare or Medicaid.

4.5 Eligibility. Subcontractor agrees and shall require Participating Providers to agree to immediately notify MA Organization in the event Subcontractor or any Participating Provider is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Subcontractor shall not, and shall require Participating Providers not to employ or contract for the provision of health care services, utilization review, medical social work or administrative services, (collectively "Eligibility Services"), with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Subcontractor shall and shall require Participating Providers to review the Department of Health and Human Services Officer of Inspector General List of Excluded Individuals and Entities and the System for Award Management (SAM), a portal for the Federal Procurement System (or any successor listing of excluded individuals or entities) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member or subcontractor for the provision of Eligibility Services. Subcontractor must and must require Participating Providers to continue to review these lists on a monthly basis thereafter to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs. MA Customers shall not have any financial liability for services or items furnished by an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is included on the preclusion list under Part 422 of the Code of Federal Regulations.

4.6 Laws. Subcontractor shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.7 Federal Funds. Subcontractor acknowledges, and agrees to inform Participating Providers, that MA Organization receives federal payments under the CMS Contract and that payments Subcontractor or Participating Providers receive from or on behalf of MA Organization are, in whole or in part, from federal funds. Subcontractor and Participating Providers are therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

4.8 CMS Contract. Subcontractor shall perform the services set forth in the Agreement in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract. Subcontractor shall also require that health care services rendered to MA Customers by Participating Providers pursuant to the Agreement are performed in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract.

4.9 Records.

(a) Privacy and Confidentiality; Customer Access. Subcontractor shall safeguard MA Customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, including the requirements established by MA Organization and the Medicare Advantage program, as applicable. Subcontractor shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law. Subcontractor shall require Participating Providers to comply with all the requirements in this section with respect to records and information related to health care services provided by Participating Providers to MA Customers pursuant to the Agreement.

(b) Retention. Subcontractor shall maintain records and information related to the services provided by Subcontractor under the Agreement including, but not limited to, MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Subcontractor shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all other records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

(c) Government Access to Records. Subcontractor acknowledges and agrees that the U.S. Department of Health and Human Services, the Comptroller General, or their designees shall have the right (directly or through the MA Organization) to audit, evaluate, collect, and inspect any pertinent books, contracts, computer or other electronic systems (including medical records and documentation), and other records and information of Subcontractor and Participating Providers related to the CMS Contract. Subcontractor shall, and shall require Participating Providers to, make available its premises, physical facilities, and equipment, records relating to MA Customers and any additional relevant information CMS may require. This right shall extend through the longer of the time periods identified in subsection 4.9(b)(i) and (ii), or ten (10) years from date of completion of any audit, whichever is later in time.

(d) MA Organization Access to Records. Subcontractor shall, and shall require Participating Providers to, grant MA Organization or its designees such audit, evaluation, collection and

inspection rights identified in subsection 4.9(c) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Subcontractor and Participating Providers reasonable notice of the need for such audit, evaluation, collection, or inspection, and will conduct such audit, evaluation, collection, or inspection at a reasonable time and place. Subcontractor shall, and shall require Participating Providers to, submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for (i) the purpose of CMS audits of risk adjustment data, and (ii) other purposes medical records from providers are used by MA Organization, as specified by CMS.

4.10 Subcontracts. If Subcontractor has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries or any other subcontractors, directly or through another person or entity, to perform any of the services Subcontractor is obligated to perform under the Agreement that are the subject of this Appendix, Subcontractor shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Subcontractor shall provide proof of such to MA Organization upon request. In addition, Subcontractor agrees to oversee and monitor, on an ongoing basis, the services Subcontractor has subcontracted to another person or entity. Subcontractor further agrees to promptly amend its agreements with such subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization, to meet any additional CMS requirements that may apply to the services. Subcontractor shall require Participating Providers to comply with all the requirements in this section.

4.11 Offshoring. Unless previously authorized by MA Organization in writing, All services provided by Subcontractor pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories. The following provisions apply to Medicare-related services that involve Medicare beneficiary protected health information ("PHI") performed pursuant to the Agreement at locations outside of one of the fifty United Sates, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands):

(a) Subcontractor represents and warrants to MA Organization that Subcontractor has in place and will comply with policies and procedures to ensure that all PHI and other personal information remains secure. Subcontractor will provide written evidence of the policies and procedures upon MA Organization's request.

(b) Subcontractor will provide prior written notice to MA Organization of (a) any material change in the Medicare-related services that involve PHI that Subcontractor performs offshore, (b) any material change in Subcontractor's policies and procedures to ensure that all PHI and other personal information remains secure, and (c) any material change in the tools and systems used by Subcontractor to ensure that all PHI and other personal information remains secure.

(c) Subcontractor is prohibited from receiving access to any PHI or other personal information of MA Customers that is not associated with services performed and products provided by Subcontractor pursuant to the Agreement. If Subcontractor receives access to PHI or other personal information of MA Customers that is not associated with Subcontractor's services performed and products provided by Subcontractor pursuant to the Agreement, Subcontractor will immediately notify MA Organization that it has received such access, return all PHI or personal information accessed by Subcontractor, and destroy any such PHI or personal information that remains in Subcontractor's possession after doing so (i.e. copies, electronic records, back-ups or temporary files).

(d) Subcontractor's services under the Agreement may be terminated immediately upon discovery of a significant security breach.

(e) Subcontractor authorizes MA Organization or its designee to conduct an audit of Subcontractor's offshore activities at least annually.

(f) Subcontractor acknowledges and agrees that MA Organization will use the results of its audit of Subcontractor to evaluate the continuation of MA Organization's relationship with Subcontractor.

(g) Subcontractor authorizes MA Organization or its designee to share the results of audits of Subcontractor with CMS.

SECTION 5
OTHER

5.1 Payment. MA Organization or its designee shall promptly process and pay or deny a Participating Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Subcontractor or Participating Providers are responsible for making payment to subcontracted providers for services provided to MA Customers, Subcontractor shall, and shall require Participating Providers to, promptly process and pay or deny such providers no later than sixty (60) days after Subcontractor or a Participating Provider receives request for payment for those services from subcontracted providers.

5.2 Regulatory Amendment. MA Organization may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, CMS. MA Organization shall provide written or electronic notice to Subcontractor of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Subcontractor will not be required in order for the amendment to take effect.

5.3 Survivability. The terms of this Appendix shall survive the termination of the Agreement regardless of the reason for termination.

SEVENTH AMENDMENT
TO THE DENTAL SERVICES AGREEMENT

This Seventh Amendment to the Dental Services Agreement (this "Amendment"), is entered into as of August 1, 2020 (the "Amendment Effective Date") by and between Dental Benefit Providers, Inc. ("Vendor") and UnitedHealthcare of Louisiana, Inc. ("United").

WHEREAS, the parties entered into a Dental Services Agreement effective January 1, 2014, as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of Covered Services to United Members.

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. Exhibit A, "Compensation for Services Addendum" to the Agreement is hereby deleted in its entirety and replaced with Exhibit A, "Compensation for Services Addendum", attached hereto.

3. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

DENTAL BENEFIT PROVIDERS, INC.

By: DocuSigned by: Michael C. Brody C3CAB41D936224AE...

Print Name: Michael C. Brody

Print Title: Assistant Secretary

UNITEDHEALTHCARE OF LOUISIANA, INC.

By: DocuSigned by: Michael J. Balcer 59ED99BC9F0C434...

Print Name: Michael J. Balcer

Print Title: Chief Financial Officer

EXHIBIT A
COMPENSATION FOR SERVICES ADDENDUM

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the Benefit Plans issued and/or administered by United and identified by United (and agreed to by Vendor) as a Benefit Plan for which the services shall be provided. United shall pay Vendor a services fee (the "Monthly Fee") according to the rates set forth in the table below.

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
E&I	Commercial	EHB - Admin	Dental		[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid Value Add - Adult >/= 21 Years	Dental	LA	[redacted]	PMPM	ASO

* If the Service Area listed above is left blank, the rate applies to all locations where United is authorized to do business, unless otherwise indicated.

"ASO" shall mean any Benefit Plan for which (a) Vendor is responsible only for providing administrative services in connection with the Benefit Plan and (b) Payor is fully responsible for the cost of any services or supplies that a Member receives for Covered Services from a Participating Provider.

"Full Service" shall mean any Benefit Plan for which Vendor is responsible for providing administrative services and is financially responsible for the cost of Covered Services covered by this Agreement.

SECTION 2
PAYMENT TERMS

2.1 Standard Payment Terms

United shall pay all Monthly Fees on or before the fifteenth (15^{th}) business day of the month following service. United shall calculate Monthly Fees using an estimate of the number of Members based on the then current information available to United for that month. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Members.

2.2 Settlement of Accounts

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter than that set forth above, as long as the due date is specified.

2.3 Cost Sharing Reductions

With respect to any Service designated as a "Full Service" rate in Section 1 Compensation for Vendor Services, United shall pay to Vendor any cost sharing reduction payment that United has or shall receive pursuant to Section 1402 of the Patient Protection and Affordable Care Act of 2010 (as amended), to the extent that such cost sharing reductions are attributable to Covered Services for which the Vendor is financially responsible under this Agreement.

SECTION 3
COMPENSATION TO PROVIDERS

3.1 Compensation to Participating Providers.

So long as United has delegated Claims Administrative Services to Vendor:

(a) For all ASO Benefit Plans, Vendor shall adjudicate and Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the clean claim.

(b) For all Full Service Benefit Plans, Vendor shall adjudicate and pay a participating provider clean claim within thirty (30) days of receiving the clean claim or as may be set forth in the Provider Agreement.

In the event that United has not delegated Claims Administrative Services to Vendor for a Full Service Benefit Plan, Vendor shall adjudicate claims and be financially responsible for Covered Services; Payor shall pay a Participating Provider clean claim within thirty (30) days of receiving the claim based on adjudication by Vendor.

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Subcontract") between UnitedHealthcare of Louisiana, Inc. ("United") and subcontractor named in the agreement to which this Appendix is attached (the "Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the State of Louisiana's Healthy Louisiana and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. Subcontractor shall comply with all provisions of this Appendix to the extent applicable to Subcontractor's services under the Subcontract. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Agreement:** An executed contract between Subcontractor and a Provider for the provision of Covered Services to persons enrolled in the State Program(s).

2.2 **Covered Person(s):** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement and/or Subcontract.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or LDH:** The Louisiana Department of Health.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement with Subcontractor for the provision of Covered Services to Covered Persons.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract with LDH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Healthy Louisiana and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services - and that are needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services also include services defined as such under 42 U.S.C. § 1395dd(e) ("anti-dumping provisions").

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Although a service may be deemed medically necessary, it does not mean the service will be covered under the State Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards; Hours of Operation; Appointments. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, including Section 7.2, and as further described in the applicable provider manual.

3.3 Antitrust. Provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any State Program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Healthy Louisiana. For purposes of this assignment clause, "Provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries

3.4 Medicaid or CHIP Participation. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in United's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. United will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals

3.6 Electronic Visit Verification (EVV). Subcontractor must, and shall require Provider to use the state-contracted electronic visit verification (EVV) system in accordance with the timeframes set forth in the 21st Century Cures Act and as directed by LDH.

3.7 Health Records. Provider agrees to cooperate with United to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards

3.8 Overpayments. Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment.

3.9 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 C.F.R. §§ 417.479, 438.3, 422.208, and 422.210 . Neither United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

3.10 Disclosure. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 C.F.R. §§ 455.100-107 and 455.400-470. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 C.F.R. § 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 C.F.R. § 455.434.

Provider shall report to United loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of receipt of notification, if required to be accredited. Provider shall also immediately report cancellation of any required insurance coverage, licensure, or certification to United.

3.11 Cultural Competency and Access. Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired

for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities

3.12 Overpayments. Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment

3.13 Data and Reports. Provider agrees to cooperate with and release to United any information necessary for United to comply with the State Contract and federal and state law, to the extent applicable to Provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters, and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. All reports and data must be provided within the timeframes specified and in a form that meets United and State requirements. By submitting data to United, Provider represents and attest to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.14 Claims Information. Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Provider shall submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

Provider is encouraged, as an alternative to the filing of paper-based claims, to submit and receive claims information through electronic data interchange (EDI).

3.15 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State

and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied. Provider must report loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of recei9pt of notification, if required to be accredited.

3.16 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with United's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.17 Non-Discrimination. Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability

3.18 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

3.19 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

3.20 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

3.21 Advance Directives. Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 489, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.22 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

3.23 Termination. In the event of termination of the Agreement, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims.

3.24 Complaints and Appeals. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with LDH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have a correct and adequate supply of such public notices.

3.25 Health Care-Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to United any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438, and 447.26.

3.26 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH has the right to direct United to impose financial consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

3.27 Clinical Laboratory Improvements Act (CLIA) certification or waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services

performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services

3.28 Hospital Providers. As applicable, Provider must register all births through LEERS (Louisiana Electronic Event Registration System) administered by the LDH/Vital Records Registry. Hospital Providers must notify United and LDH of the birth of a newborn when the mother is a member of United, complete the web-based LDH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to LDH.

3.29 Mental Health and Substance Use Providers. Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable.

3.30 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable State Program approved cost sharing, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services ("HHS") and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR §447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

If the services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. Subcontractor shall, and to the extent applicable to Provider in performance of the Agreement, shall ensure Provider indemnifies, defends, and holds LDH and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Subcontractor or Provider, its agents, officers, employees or contractors arising from the Agreement. LDH may waive this requirement for public entities if Subcontractor or Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time. Subcontractor and Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Subcontractor and Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Subcontractor and Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given

access to and can request copies of the Covered Person's medical records, to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, LDH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Records Access. Subcontractor acknowledges and agrees and shall require Provider to acknowledge and agree that the State, HHS, Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Subcontractor and Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the Subcontractor agrees, and shall require Provider to agree, to not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. Subcontractor and Subcontractor's Provider agrees that this contract creates for the MFCU an enforceable right for which the MFCU can petition the court in the event of non-compliance with an information, records or data request.

Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records to the extent and in the manner provided by La.R.S. § 40:1299.9

(d) Records Retention. As required under State or federal law or the State Contract, Subcontractor shall and shall require Provider to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposal of records must be requested and approved by United if the Agreement is continuous. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

(d) Records Upon Audit. Subcontractor shall require Provider to have online retrieval and access to documents and files for audit and reporting purposes for 10 years in live systems and an additional 4 years in archival systems. Historical encounter data submission shall be retained for a period not less than 10 years, following generally accepted retention guidelines. Services which have a once in a lifetime indicator (i.e., appendix removal, hysterectomy) are denoted on LDH's procedure formulary file, and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID, provider NPI, and/or ICN (internal control number) to include pertinent claims data and claims status. Audit trails shall be maintained online for no less than 6 years. Provider shall provide access to information in machine-readable format within 48 hours of requests for information less than 6 years old and within 72 hours of requests for information greater than 6 years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress or unresolved, information shall be kept in electronic form until all tasks or proceedings are completed. Under no circumstances shall the Provider destroy or dispose of any such records, even after the expiration of the retention periods provided above, without the express prior written permission of LDH

(e) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to LDH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Audit; Investigations.

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor acknowledges and agrees and shall require Provider to acknowledge and agree that all agencies listed above or any of their designees shall be provided with access to all documents and records related to the program services and the right to examine, evaluate and investigate, including on-site audits and examinations and private interviews of Subcontractor's clients and employees. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as

often as they may deem necessary during the State Contract period and for a period of ten (10) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs with no charge to the agencies listed above.

(b) By LDH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of LDH.

(c) Subcontractor shall require Provider to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. Provider agrees that the Agreement creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

(d) Subcontractor shall require Provider to agree that the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Provider, or of the Provider's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under United's contract with the State. Provider will make available, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Covered Persons. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate and audit the subcontractor at any time.

(e) Subcontractor shall require Provider to make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG),

HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require Providers to agree that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 C.F.R. §§ 160.101 et seq., 162.100 et seq., and 164 et seq., as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 C.F.R. §§ 2.1 et seq., 431.300-307, 434.1 et seq., 438.224 and 438.3 (as applicable).

Subcontractor will require that Provider further acknowledge that, in some cases, Provider will have access to information on individuals with whom Provider has no treatment or other relationship. In such cases Provider will abide by all requirements under HIPAA and ensure that the confidentiality of such information is fully maintained.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with the Agreement and Subcontract, including the HHS, the Department and other individuals or entities as may be required. Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA

regulations. Subcontractor shall, and shall require Provider to notify United and LDH of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the LDH with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and LDH to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract, MCO Manual and LDH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract, MCO Manual and LDH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and LDH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the LDH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall require Provider to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor or Provider in their performance of the Subcontract and Agreement. Subcontractor and Provider understand that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Subcontractor's or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor and Provider understand and agree that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Subcontractor shall require Provider to agree that they will provide medical records to United upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR § 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Subcontracts. If Subcontractor or Provider subcontracts or delegates any functions of the Subcontract or Agreement, in accordance with the terms of the Subcontract or Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. Subcontractor and Provider further agree to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

4.11 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR § 93, 100 et seq., as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.12 Excluded Individuals. Subcontractor certifies, and shall require Provider to certify to the best of their knowledge and belief that neither it nor any of its principals, nor any Providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under 42 U.S.C. § 1320a-7; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. United will exclude from its network any provider who has been excluded from the Medicare, Medicaid or CHIP program in any state. United may also terminate the Agreement if Subcontractor or Provider or Subcontractor's or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Subcontract and Agreement must be submitted to United to submit to the Department for prior approval..

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist LDH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network, employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA), Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the False Claims Act (established under sections 31 U.S.C. §§ 3729 - 3733), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 C.F.R. § 438.600; (b) cite administrative remedies for false claims and statements established by 31 U.S.C. § 3801 et seq and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)), include as part of such written policies, detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.16 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in LDH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information. Provider is encouraged to adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC). If Provider is an emergency departments (EDs), Provider agrees and is required to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry would consist of three basic attributes: (a) the ability to capture and match patients based on demographics information, (b) the ability to identify the facility at which care is being sought, and (c) at minimum, the chief complaint of the visit. These three pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country.

4.17 Insurance Requirements. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. LDH

and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider. Subcontractor shall and shall require that Provider immediately report cancellation of any required insurance coverage, licensure, or certification to United.

4.18 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.19 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United. If Subcontractor or Provider receives consent, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Subcontractor and/or Provider as applicable agree to promptly amend agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

4.20 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.21 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.22 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or LDH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

If Provider discovers an error or a conflict with a previously adjudicated encounter claim, Subcontractor and/or Health Plan shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or if circumstances exist that prevent

Subcontractor and/or Health Plan from meeting this time frame a specified date shall be approved by LDH.

When Subcontractor has entered into an alternative reimbursement arrangement with Provider, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the Subcontractor.

4.23 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.24 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by LDH.

4.25 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the amount, duration, and scope of benefits and services of Subcontractor's and/or Provider's practice.

4.26 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.27 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall require Provider to agree to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Subcontract and Agreement. Subcontractor understands, and shall require Provider to agree that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor and Provider stipulate that Louisiana law, without regard to its conflict of laws provision, will prevail if there is a conflict between the state law where the material contractor is based and Louisiana law. Subcontractor shall require that Provider agrees that Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.28 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

4.29 Healthcare Oversight Agency Compliance. Subcontractor shall, and shall require Providers to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities that manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but do not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and United, Subcontractor or Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. United, Subcontractor and/or Provider agree that the State Contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

SECTION 5
UNITED REQUIREMENTS

5.1 Prompt Payment. United shall pay Subcontractor pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the State Contract.

If LDH discovers an error or a conflict with a previously adjudicated encounter claim, United will adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH.

5.2 No Incentives to Limit Medically Necessary Services. United shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not

interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

5.4 Communication with Covered Persons. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Subcontract shall be performed in accordance with the requirements of the State Contract and LDH issued guides, the applicable provisions of which are incorporated into the Subcontract by reference. Nothing in the Subcontract relieves United of its responsibility under the State Contract. If any requirement or provision of the Subcontract or this Appendix is determined by LDH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Subcontract or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Subcontract and this Appendix shall remain in full force and effect.

6.2 Monitoring. United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Subcontract and shall perform periodic formal

reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or LDH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established under the State Contract.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of LDH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and LDH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that LDH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the

State Contract. United will submit and obtain prior approval from LDH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of LDH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.10 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by LDH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

In addition, United agrees to comply with the claims processing requirements in the State Contract. At a minimum, United shall run 1 provider payment cycle per week, on the same day each week, as determined by United. United shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments. United shall encourage that its providers submit and receive claims information through electronic data interchange (EDI) as an alternative to the filing of paper-based claims. Claims shall be processed in adherence to information exchange and data management requirements specified in the State Contract. United shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud, abuse, or waste or otherwise included on the Department of Health and Human

Services Office of Inspector General exclusions list, or employs someone on this list. United shall not pay any claim submitted by a provider that is on payment suspension and/or withhold under the authority of LDH or its authorized agent(s). United shall inform all network providers about Clean Claim requirements. United shall make requirements and guidelines for claims coding and processing that are specific to Provider types available to network providers. United shall notify providers 90 calendar days before implementing changes to claims coding and processing guidelines, or as soon as possible if directed by LDH pursuant to state or federal law to implement such change earlier.

6.11 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.12 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.13 Enrollment. The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Exclusivity. Nothing in the Subcontract or this Appendix shall be construed as prohibiting or penalizing Subcontractor for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other subcontractors or providers.

6.16 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.17 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

Exhibit B: Material Subcontractor Response Template

Proposer (MCO) name:
UnitedHealthcare of Louisiana, Inc.
Material subcontractor name:
MARCH® Vision Care Group, Incorporated
Description of the Proposer's role and material subcontractor's role:
Proposer's Role: To provide high quality health care services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program, while using the most cost-effective manner and in accordance with LDH's terms and conditions. **Material Subcontractor's Role:** To provide routine vision and medical eye care, within the scope of an optometrist's licensure, benefit administration, to include provider network development, credentialing and education, provider customer service, eligibility and benefit maintenance, reporting (ad hoc, state-mandated and client specific) and claims processing.
Explanation of why the Proposer plans to subcontract this service and/or function:
To support UnitedHealthcare of Louisiana in its mission of providing high quality vision and eye care benefit administration services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program, utilizing the most cost-effective manner and in accordance with LDH's terms and conditions. **For example, to best serve Louisiana enrollees and to meet LDH's goals, MARCH will:** **Ensure enrollees ready access to care**, by providing a vast network of providers and support personnel in Louisiana. With more than 400 providers at more than 350 locations, the provider community comprises optometrists, ophthalmologists, opticians, and retail locations to make sure enrollees have access and choice. Additionally, some providers, for example Walmart, will have extended hours and will be available at night and during the weekend. MARCH continually reviews its network to verify participating providers are located close to the enrollees. To help promote diabetic enrollees receiving their annual diabetic retinopathy exam, MARCH sends notices to its provider community reminding them of the importance to reappoint diabetic enrollees. **Improve enrollee health**, by sending letters to the PCP community alerting the PCP the enrollee has received their annual eye exam. The PCP receives details of the exam, which may include information about diabetes, hypertension, or high cholesterol. This provides the PCP with the opportunity to engage with the enrollee and assist with the necessary medications, specialty referrals and disease management classes that might be available. Additionally, reports identifying diabetic members who have received care are sent to the health plan monthly. The reports will include exam details and a notation if the member has diabetic retinopathy.
A description of the material subcontractor's organizational experience:

MARCH® Vision Care Group, Incorporated.

MARCH was founded by Glenville A. March, Jr., M.D. and Cabrini T. March, M.D. over 20 years ago, with a groundbreaking platform in mind for delivering quality vision care — a platform to focus on early disease detection via the use of state-of-the-art technology to help improve communication between enrollees and their doctors.

Using this platform and equipped with extensive years of Medicaid vision care experience, MARCH provides customized service to their clients and their enrollees, and they offer a broad range of fully customizable vision care programs. They collaborate with highly trained eye care professionals who share a commitment to MARCH's mission — to improve health via high-quality affordable vision care that focuses on early detection, education, and management through innovative, enrollee-oriented solutions. MARCH's nationwide network of eye care professionals includes ophthalmologists, optometrists, and opticians, who provide enrollees with convenient access to care — including weekends and evening hours — in rural and urban areas. Other functions include provider network development, credentialing, recredentialing and education, provider customer service, eligibility and benefit maintenance, reporting (ad hoc, state-mandated, and client-specific) and claims processing. Claims processing, provider credentialing and call center operations continually meet and exceed client and state requirements.

Today, MARCH serves more than 8,000,000 enrollees nationally, providing various products and programs for vision and sight related health needs for many population types (e.g., Medicare, MMP and Medicaid). In Louisiana, they have more than 350 locations with more than 400 vision access points for commercial and public sector programs, serving more than 469,000 enrollees.

For the public sector, MARCH has supported the Medicaid market since 2001; currently, MARCH administers vision benefits through 87 Medicaid programs for more than 8,000,000 enrollees in 26 states plus the District of Columbia. Medicaid population types include, for example, expansion, CHIP, dual eligible, D-SNP, Medicare and TANF.

Since 2015, MARCH has administered and is administering routine and medical vision benefits for Healthy Louisiana recipients; currently, they serve more than 469,000 Medicaid enrollees. Routine vision consists of comprehensive eye exams and eyewear. The medical vision benefit includes services that are within the scope of licensure for an optometrist. Equipped with a statewide provider network of more than 400 providers in 350 locations in urban and rural areas, MARCH works with its health plan partners to make sure primary care physicians (PCPs) are informed when enrollees receive eye care from a MARCH provider. Information shared with the PCP includes services performed and diagnosis from the claim along with the eye care professional's contact information.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:

We monitor and manage the performance of subcontractors through the mechanisms described below. These mechanisms facilitate our oversight of the subcontractors and allow us to evaluate performance, especially with respect to state contractual requirements. Unless otherwise noted, we use these approaches for both external nonaffiliate subcontractors and our affiliate entities within UnitedHealth Group:

- ***Operating Arrangements:*** The operating document incorporates a description of the required functions and service levels, the process by which we assess performance, the recourse we have if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate), and the authority of Karl Lirette and the executive team to drive change. Relationships are constructed,

formalized, and managed with the consent of LDH, the subcontractor and UnitedHealthcare. LDH has the right to review and approve or disapprove all subcontracts for the services provided under this contract.

- ***Vendor Collaboration Meeting:*** As appropriate, we invite representatives from our subcontractors to our regular operations meetings, promoting understanding of how each functional area is dependent upon the success of the others. During these meetings, we provide direction for our subcontractors and verify their quality and effectiveness is sufficient to meet objectives. Local functional area business owners also report on subcontractor performance and measurements. Operations meetings include:
  - Feedback and oversight
  - Review of policies and procedures
  - Training and education
  - Monitoring of key performance indicators
  - Effective lines of communication
  - Responding to issues/escalating when necessary
- ***Joint Operating Committee (JOC):*** Our Joint Operating Committee monitors subcontractor performance monthly. An expedited meeting may be called to address critical issues in a timely manner as determined by our leadership and our subcontractor(s). The scope of the JOC includes developing compliance strategies and initiatives to support the subcontractor's performance such as:
  - Overall review of business performance
  - Assessment of key compliance/regulatory issues and risks
  - Audit planning and reporting
  - Escalation of issues, especially from local health plans
  - Review of fraud, waste, and abuse prevention efforts
  - Confirmation of monthly checks of federal and state exclusion lists
  - Response to identified issues

  Membership of the JOC includes Louisiana plan leadership, national representatives and key business leads from UnitedHealthcare's Community & State (Medicaid) organization, and operational partners.
- ***Dedicated Staff:*** We designate accountable relationship owners from the Louisiana health plan in the appropriate functional area to work with specific subcontractors. The local relationship owner works with regional and national relationship owners to perform this oversight. Subcontractors may require additional attention when their responsibilities are of a critical nature or where performance warrants additional oversight. We understand that such steps are necessary for high quality, given the size of our health plan and the large number of members and providers that depend on us. These staff members monitor and drive improvement in our subcontracted services.
- ***Statistics and Reports:*** Subcontractors are required to report key performance indicators on a monthly or basis. These reports allow UnitedHealthcare staff to monitor and evaluate subcontractors, as well as indicate action steps for improvements. Review of these statistics occurs in monthly and quarterly committee reviews.
- ***Collaboration Calls:*** During monthly or as appropriate collaboration calls, our CEO, COO and CMO (as needed), members of the local team meet with executives from our affiliate organizations, allowing for constant exchange of best practices, problem-solving and innovations that are working in other markets. Executives from our claim's operations, member and provider services centers, provider contracting, pharmacy and other functional

areas attend this meeting as needed. In addition, this dialogue allows our executive staff to provide direct feedback to our partners on their service quality and reinforce the prioritization of our Medicaid programs to promote contract compliance. UnitedHealthcare uses these overall monitoring approaches and mechanisms to identify and prioritize areas for improvement, set quantifiable goals and metrics, and communicate clear expectations. By creating a systematic approach to evaluate and improve our operations with our subcontractors, we have a process that promotes ongoing identification and remediation of operational challenges and implementation of best practices and innovations.

- ***Annual Review:*** We will conduct an annual review of the subcontractor's performance. This review will include, at a minimum, any performance concerns identified by LDH. We will provide LDH with a copy of the review and any corrective action plans developed as a result.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Regulatory Appendix Pg. 13 Section 4.7
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Base Agreement Pg. 26
3	Specify the effective dates of the subcontract agreement.	Amendment 2 Pg. 1 Preamble Base Agreement Pg. 14 Section 9
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Regulatory Appendix Pg. 22 Section 6.3
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Regulatory Appendix Pg. 22 Section 6.3
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Regulatory Appendix Pg. 22 Section 6.3
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Regulatory Appendix Pg. 10 Section 4.4(e)
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Regulatory Appendix Pg. 23 Section 6.7
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Regulatory Appendix Pg. 23 Section 6.1

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Regulatory Appendix Pg. 1 Section 2.2
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Regulatory Appendix Pg. 18 Section 4.20
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Regulatory Appendix Pg. 5 Section 3.15
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Regulatory Appendix Pg. 19 Section 4.26
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Regulatory Appendix Pg. 2 Section 3.1(b)
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Regulatory Appendix Pg. 20 Section 4.31
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Regulatory Appendix Pg. 9 Section 4.4(a)
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Regulatory Appendix Pg. 10 Section 4.4 (d)

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Regulatory Appendix Pg. 12 Section 4.5 (e)
19	INTENTIONALLY LEFT BLANK	
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Regulatory Appendix Pg. 5 Section 3.15
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Regulatory Appendix Pg. 22 Section 6.2
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Regulatory Appendix Pg. 22 Section 6.2
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Regulatory Appendix Pg. 8 Section 3.26
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Regulatory Appendix Pg. 18 Section 4.23

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Regulatory Appendix Pg. 13 Section 4.6
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Regulatory Appendix Pg. 23 Section 6.10 Amendment 2 Pg. 1 Number 2
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Regulatory Appendix Pg. 23 Section 6.10
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Regulatory Appendix Pg. 18 Section 4.23
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Regulatory Appendix Pg. 18 Section 4.23
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Regulatory Appendix Pg. 8 Section 4.1
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Regulatory Appendix Pg. 8 Section 4.2

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Regulatory Appendix Pg. 17 Section 4.18
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Regulatory Appendix Pg. 19 Section 4.28
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Regulatory Appendix Pg. 22 Section 6.3
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Regulatory Appendix Pg. 23 Section 6.8
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Regulatory Appendix Pg. 19 Section 4.27
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Regulatory Appendix Pg. 5 Section 3.15
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Regulatory Appendix Pg. 19 Section 4.24
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Regulatory Appendix Pg. 16 Section 4.13

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Regulatory Appendix Pg. 25 Section 6.14
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Regulatory Appendix Pg. 19 Section 4.23
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Regulatory Appendix Pg. 19 Section 4.29
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Regulatory Appendix Pg. 3 Section 3.3

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Regulatory Appendix Pg. 11 Section 4.5(c)

ADMINISTRATIVE SERVICES AGREEMENT

THIS ADMINISTRATIVE SERVICES AGREEMENT (this "Agreement"), effective the later of: (i) February 1, 2015 or (ii) such date as specified by the appropriate regulatory agency(ies), regardless of the execution date hereof (the "Effective Date") is by and between **MARCH VISION CARE GROUP, INCORPORATED** ("Vendor") and **UNITEDHEALTHCARE OF LOUISIANA, INC.** ("United"). For services provided on or after its Effective Date, this Agreement supersedes and replaces any and all other agreements, whether written or oral, between the parties regarding the subject matter contained herein.

WHEREAS, Vendor is a professional medical corporation;

WHEREAS, Vendor provides certain network management and/or administrative services related to the provision of Covered Services to Covered Persons;

WHEREAS, United issues and/or administers Benefit Plans on behalf of itself and Payors for the benefit of Covered Persons;

WHEREAS, in order to effectively carry out its operations, United desires to contract with Vendor for the provision of certain network management and/or administrative services; and

WHEREAS, this Agreement describes the services Vendor shall provide to United and Covered Persons whereby the services shall be described in detail in a separate Services Addendum to this Agreement.

NOW THEREFORE, in consideration of the terms and conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, Vendor and United hereby agree as follows:

SECTION 1
APPLICABILITY STATEMENT

This Agreement outlines the understanding, rights and obligations between Vendor and United regarding the administration of one or more health care program(s). The parties are entering into this Agreement for the provision of certain administrative and other services related to the delivery of covered health care services and products for individuals enrolled in the programs described in Exhibit A, attached to this Agreement.

SECTION 2
DEFINITIONS

As used in this Agreement and all exhibits attached hereto, the following terms shall have the

meanings set forth below. Additional definitions may be set forth in the attached exhibits.

2.1 **Benefit Plan:** A certificate of coverage, summary plan, benefit plan or description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payor is obligated to provide coverage of Covered Services for a Covered Person.

2.2 **CMS:** The Centers for Medicare and Medicaid Services.

2.3 **Copayment:** An amount identified in a Benefit Plan, if any, that is due and payable by a Covered Person directly to a Provider for specific Covered Services. Copayments typically are described as a flat dollar amount for each particular type of service or supply.

2.4 **Coinsurance:** An amount identified in a Benefit Plan, if any, that is due and payable by a Covered Person directly to Providers for specific Covered Services, independent of any required Copayments or Deductibles. Coinsurance amounts typically are described as a percentage of the Provider's charges or contracted fees for the applicable services or supplies.

2.5 **Covered Person:** A person eligible and enrolled with United to receive coverage from a Payor for Covered Services.

2.6 **Covered Person Expense:** Any amounts that are the Covered Person's responsibility to pay a Provider for Covered Services in accordance with the Covered Person's Benefit Plan, including Copayments, Coinsurance, and Deductibles.

2.7 **Covered Services:** A health care service or product for which a Covered Person is entitled to receive coverage from a Payor, pursuant to the terms of the Covered Person's Benefit Plan. For the purposes of this Agreement, Covered Services refer to the services to be provided by Vendor to United and Covered Persons as further defined in the Services Addendum, a certificate of coverage, summary plan, benefit plan or description, attached to, and incorporated by reference into, this Agreement.

2.8 **Deductible:** An amount for Covered Services that a Covered Person must pay, if any, before the Covered Person is eligible for coverage under the Covered Person's Benefit Plan.

2.9 **HIPAA:** The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (codified as amended in scattered sections of 42 U.S.C.), and its privacy, security and administrative simplification provisions as set forth under 45 C.F.R. Parts 160 and 164.

2.10 **Participating Provider or Provider:** A licensed or otherwise appropriately qualified and credentialed health care professional or entity that has executed a Provider Agreement with Vendor, directly or through another entity, to provide Covered Services to Covered Persons.

2.11 **Payor:** An entity obligated to a Covered Person to provide reimbursement for Covered Services under the Covered Person's Benefit Plan and authorized to access Participating Providers' services rendered pursuant to the Provider Agreement.

2.12 **Provider Agreement:** An agreement between Vendor and a Participating Provider that sets forth the terms and conditions under which the Participating Provider participates in one or more of Vendor's networks of providers.

2.13 **Service Area:** The geographic area in which United is authorized by a state to provide coverage for health care services to Covered Persons.

2.14 **Services Addendum:** A description of the services to be provided by Vendor documented in writing and attached to, and incorporated by reference into, this Agreement. For purposes of this Agreement, Service Areas shall be as set forth in Exhibit A.

2.15 **State:** Louisiana or any of its designated regulatory agencies.

SECTION 3
VENDOR SERVICES

3.1 **Services Addendum.** Vendor shall provide those services for the products and programs identified on Exhibit A, and as set forth in the Services Addendum attached to this Agreement as Exhibit B.

3.2 **Fines; Penalties.** Vendor shall be responsible for any and all penalties that the State or CMS may assess against United under United's contract with CMS or the State, as the case may be, that directly arise from Vendor's failure to provide, or delay in providing, the services described in this Agreement. United reserves the right to assess penalties on a pass-through basis equal to those penalties that CMS or the State, as the case may be, may assess against United. Vendor shall be subject to the corrective action plan requirements in Section 7.5. In no event shall Vendor be responsible for any fines or penalties that arise from United's failure to perform, or delay in performing, United's obligations under this Agreement.

3.3 **Performance Level Standards and Specifications.** Vendor shall be subject to any performance level standards set forth in Exhibit B, Services Addendum, Exhibit B-2, Performance Level Standards, and applicable standards set by the State and or CMS, and, within a reasonable amount of time using commercially reasonable efforts after, any additional and/or modified service level specifications developed in accordance with this Section 3.3. United shall be responsible for developing and maintaining additional performance level specifications identified from federal and/or State contractual obligations. United and Vendor represent and warrant as follows:

(a) United represents and warrants that it shall provide such additional performance level standards and specifications (and any updates thereto) in a timely and accurate manner to

Vendor. Vendor agrees to prepare and maintain operational documents in the form of policies and procedures to ensure ongoing compliance with the performance level standards set forth on Exhibit B and B-2 and such performance level specifications as may be required by United, or federal/State law or contract from time to time. Vendor represents and warrants that it shall ensure compliance with all such operational policies and procedures during the term of this Agreement and report immediately or as soon as practicable non-performance or failure to observe a performance level standard or specification or related obligation of which it becomes aware.

(b) Each party also reserves the right to amend such performance level standards or specifications and policies and procedures from time to time to ensure proper performance of the services and compliance with applicable federal and State contractual obligations or law.

(c) The parties shall also meet from time to time and/or form a joint committee to ensure observance of all applicable performance metrics, reporting obligations and performance level standards and specifications as set forth in the applicable operational policies and procedures.

SECTION 4
UNITED AND PAYOR RESPONSIBILITIES

4.1 **Covered Person Eligibility Information.** At least monthly, on a date mutually acceptable to United and Vendor, United shall provide Vendor with a current list of eligible Covered Persons in an electronic format mutually agreeable to both parties. The eligibility information shall be prepared and provided to Vendor at United's expense. Vendor shall treat the information received under this Section as confidential and shall not distribute or furnish such information to any other person or entity, except as necessary pursuant to Vendor's standard practices and as permitted by law, to provide or arrange for Covered Services. In the event United is unable to provide Vendor with a current list of eligible Covered Persons in an electronic format, the parties agree to adjust the compensation payable to Vendor pursuant to this Agreement should such alternative process cause Vendor to incur additional costs. Subject to retroactive eligibility changes required by CMS or the State, Vendor shall be entitled to rely on the most current eligibility information and Benefit Plan documents in its possession in providing services under this Agreement, including processing claims for Covered Services, if applicable.

4.2 **Retroactive Adjustments of Eligibility**. Vendor acknowledges that there will be favorable and unfavorable retroactive adjustments to Covered Person eligibility. United shall use its best efforts to minimize such adjustments. Notwithstanding the foregoing, the parties agree that Vendor shall not be financially liable for any claims for Covered Services for Covered Persons that are related to such retroactive adjustments of greater than sixty (60) days, except that the sixty (60) day limitation will not apply if the retroactive adjustment is imposed by the State or CMS. United shall notify Vendor within a reasonable amount of time of receipt whenever a

retroactive adjustment is received and imposed by the State or CMS and United shall provide evidence thereof upon request.

4.3 **Benefit Plans.** This Agreement is not intended nor shall it be deemed or construed to modify the obligations of United or a Payor to Covered Persons as established under any Benefit Plan. United acknowledges that it retains the ultimate responsibility to assure delivery of all benefits required under a Benefit Plan between United and a Covered Person.

4.4 **Notice to Covered Persons.** United will give Covered Persons the information and documents necessary to obtain Covered Services within a reasonable period of time before coverage begins or as soon as possible thereafter if such information is not available prior to the effective date of coverage. In the event this Agreement is terminated, United will notify all Covered Persons of the discontinuance of services Vendor is providing under this Agreement.

4.5 **Responsibility for Information.** United understands and agrees that Vendor is not responsible for any delay in the performance of this Agreement or for any non-performance under this Agreement if the delay or non-performance is caused or materially contributed to by United's failure to: (i) furnish any of the information described in this Agreement; or (ii) provide funds for the payment of benefits or compensate Vendor.

4.6 **New Benefit Plans and Changes to Vendor Services.** United shall use commercially reasonable efforts to notify Vendor in writing at least ninety (90) days prior to any modification of an existing Benefit Plan, development of a new Benefit Plan or expansion of its service area to a geographic area of the country not originally contemplated under this Agreement. In the event that such modification, development or expansion is deemed by Vendor to be a material change to Vendor's obligations under this Agreement or the pricing assumptions used in establishing rates, the parties shall negotiate to include the modification, development or expansion in this Agreement in accordance with Section 13.8.

4.7 **Covered Person Consents and/or Authorizations.** United agrees to assist Vendor in obtaining any necessary Covered Person consents or authorizations, as required under federal or State law, in order for Vendor to receive protected health information ("PHI") when necessary for Vendor to perform its obligations under this Agreement or to use such information for research, creating comparative databases, statistical analyses or other studies.

4.8 **Communication Materials and Activities.** United shall periodically inform and instruct Covered Persons through various publications and programs jointly established by United and Vendor about Covered Services available to Covered Persons. United and Participating Providers must receive Vendor's permission before using any of Vendor's trademarks, logos, copyrighted materials, or other branding materials in its communications materials.

If United produces communications materials, it shall do so at its own cost and shall submit materials that use Vendor's trademarks, logos, copyrighted or other branding materials to describe Covered Services to Vendor for Vendor's prior review and approval. Any promotional

videos may be rebroadcast and brochures made available via United's or other applicable parties' intranet solely for the purpose of providing information about Covered Services to Covered Persons, provided such materials contain an appropriate copyright or trademark acknowledgment. United shall not reproduce any marketing, advertising, or promotional materials, including but not limited to, videos, brochures, posters, newsletters and any other Vendor trademarks, logos, copyrighted materials, or other branding materials provided to United without Vendor's prior written consent..

United shall use its best efforts to include legally required notices regarding Covered Services or other legally required communications related to Vendor in its scheduled mailings at no cost to Vendor.

United shall submit communication materials to State and federal regulatory agencies for prior approval as required by and in accordance with applicable State and federal law and regulations.

4.9 **Taxes & Assessments.** If any tax, other than State or federal income taxes, or any other assessment or premium charge is assessed against United or a Benefit Plan and either Vendor or United are required by law to pay such tax, assessment or premium charge, Vendor shall report such assessment to United. As between United and Vendor, United shall be solely responsible for the payment of any such taxes and assessments. United will reimburse Vendor for taxes or other amounts that are assessed against Vendor or that Vendor is required to pay, now or in the future, relating to: (i) any Benefit Plan; (ii) any benefit payments under any Benefit Plan; (iii) this Agreement; or (iv) Vendor's fees or services under this Agreement (but not taxes on Vendor's net income or gross receipts). The parties will work cooperatively and reasonably to reach a mutual determination as to whether any such tax imposed should be paid or disputed. United will also reimburse Vendor for any costs or expenses reasonably incurred by Vendor relating to such tax, including costs and reasonable attorneys' fees incurred in disputing such tax, and any interest, fines, or penalties relating to such tax, except to the extent that such interest, fines or penalties resulted from Vendor's untimely handling of the matter.

4.10 **Identification Cards.** United shall ensure that Covered Persons receive an identification card and that a mutually agreeable process is established for referring Covered Persons to Vendor when appropriate.

4.11 **Non-Interference with Advice to Covered Persons.** Nothing in this Agreement is intended to prohibit or restrict Participating Providers or other health care professionals from advising or advocating on behalf of a Covered Person about:

(a) the Covered Person's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the Covered Person to provide an opportunity to decide among all relevant treatment options;

(b) the risks, benefits and consequences of treatment or non-treatment; and

(c) the opportunity for the Covered Person to refuse treatment and express preferences about future treatment decisions.

4.12 **United Compliance with Vendor's Provider Agreements.** United will use commercially reasonable efforts to comply with the applicable obligations set forth in Vendor's Provider Agreements.

SECTION 5
PAYMENT; PAYMENT TERMS

5.1 **Vendor Services Fee.** For services provided under this Agreement, United shall pay Vendor the rates set forth in the Compensation for Services Exhibit attached to this Agreement as Exhibit A.

5.2 **Payment to Participating Providers.** Any payments to Participating Providers for the provision of Covered Services shall be made pursuant to the Vendor's Provider Agreement with such Provider. The obligation for payment for Covered Services rendered to a Covered Person is solely that of Vendor.

5.3 **No Incentive Payments.** Vendor receives no incentive payment based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings to reduce amounts of necessary or appropriate medical care.

5.4 **Covered Person Protection.** This Section applies when any applicable statutes and regulations require that the Covered Person be held harmless from any and all costs, which are the legal obligation of Vendor, United or another Payor.

Vendor and United agree that in no event, including, but not limited to, non-payment for Covered Services provided to Covered Persons; insolvency of Vendor, United or another Payor; or breach by United or Vendor of any term or condition of this Agreement or any term or condition of a Provider Agreement, shall Vendor, United or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Covered Person or persons acting on behalf of the Covered Person for Covered Services eligible for reimbursement under this Agreement.

The provisions of this Section shall: (i) be construed in favor of the Covered Person; (ii) survive the termination of this Agreement regardless of the reason for termination; and (iii) supersede any oral or written agreement, existing or subsequently entered into, between any of the parties to this Agreement or a Participating Provider and a Covered Person or the representative of the Covered Person if such agreement is inconsistent with this section.

This Section shall not prohibit collection of any allowed Covered Person Expenses. It also shall not prohibit the collection of charges for services that are not Covered Services as defined in the

Benefit Plan, provided that the Covered Person has been informed of the costs for non-covered services prior to the rendering of such services and has agreed in writing to accept responsibility for payment for such services. The Covered Person's written consent shall be in a form agreed to by the parties and in compliance with any applicable State and federal law. This provision also shall not prohibit payment for any Covered Services delivered after expiration of benefits under the relevant Benefit Plan. If requested by United, Vendor shall submit to United any Covered Person's written acknowledgement to accept responsibility for non-Covered Services provided to him/her. Vendor's Provider Agreements with Participating Providers shall require adherence to the requirements in this Section.

SECTION 6
INFORMATION SYSTEMS

To the extent required by United, Vendor shall comply with the following information systems requirements:

6.1 **Connectivity.** Vendor will maintain information technology interface capabilities, integration, messaging and connectivity with United's information systems as is reasonably necessary for Vendor to provide services under this Agreement. Vendor will modify its proprietary systems as necessary to achieve such interface, integration, messaging and connectivity.

6.2 **Maintenance and Upgrades.** Vendor will bear the cost of maintaining and upgrading its system and system interfaces as necessary to provide services under this Agreement.

6.3 **Customized Developments.** If United requests that Vendor change its system to provide services customized solely for United (i.e., systems that Vendor does not use to support any of its other customers), United agrees to pay Vendor to implement such changes.

6.4 **E-Commerce.** Vendor agrees to assist United in the development of links between United's Covered Persons' websites and Vendor's Covered Persons' website.

SECTION 7
INFORMATION; AUDITS; BOOKS AND RECORDS

7.1 **Maintaining Records.** Vendor shall maintain, and shall require, as applicable, Participating Providers, relevant employees and any subcontractors to maintain, books and records that are usual and customary for the services provided under this Agreement. All such books and records shall be maintained to clearly and accurately disclose the precise nature and details of transactions, including accounting information necessary to support the charges or fees to respective parties, in accordance with prudent standards of insurance industry recordkeeping and all applicable laws and regulations. Vendor shall preserve such records for at least ten (10) years after the date the records were created or such other period as required by applicable law or

regulation, whichever is longer. Any such records shall remain the property of Vendor, subject to any rights of Covered Persons or unless otherwise required by law.

7.2 **Privacy and Release of Records.**

(a) Vendor, United and Participating Providers shall maintain the privacy and confidentiality of all information regarding Covered Persons in accordance with any applicable laws and regulations, including HIPAA Privacy Standards. Upon request by and at the expense of United, Vendor shall obtain all applicable information and records or copies of records regarding services provided by Vendor or a Participating Provider to a Covered Person and shall release such information to United. Neither Vendor nor any Participating Provider shall transfer any identifiable Covered Person record, including a patient record, to another entity or person without written consent from the Covered Person or someone authorized to act on the Covered Person's behalf, except as permitted by applicable State or federal law.

(b) During and after the term of this Agreement, United, Vendor and their related entities may use and transfer any and all information gathered under this Agreement for research and analytical purposes in accordance with applicable State and federal law.

(c) Vendor acknowledges that in receiving, storing, processing or otherwise dealing with information about Covered Persons, it may be fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and agrees that, if so, it shall resist, in judicial proceedings, any effort to obtain access to information pertaining to Covered Persons that is expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

7.3 **Covered Person Access to Records.** Vendor shall establish and maintain procedures, and shall require Participating Providers to establish and maintain procedures, in accordance with applicable law and regulations, including but not limited to, any State regulatory appendix attached to this Agreement, to ensure timely access by Covered Persons to medical records and other health information in Vendor's possession that pertains to Covered Persons.

7.4 **Examination of Records.** Upon reasonable notice, during normal business hours and at a reasonable time and place, United or its designee shall have the right to examine any records of Vendor that relate to Vendor's obligations under this Agreement at United's sole cost and expense; provided however that, this Section 7.4 shall not apply to CMS or the State.

7.5 **Audits and Corrective Action Plans.** United shall provide Vendor with a report of any audit findings resulting from an examination by it under Section 7.4 within thirty (30) calendar days of the conclusion of an audit. In the event United notes a State or federal contract and/or regulatory deficiency(ies) during the audit, Vendor shall develop a corrective action plan. United further reserves the right to request a corrective action plan from Vendor if Vendor is assessed with any fines or penalties under Section 3.2. Such plan shall be subject to United's approval

(which shall not be unreasonably withheld), shall include specifics of and timelines for correcting the State or federal contract and/or regulatory deficiency(ies) (which shall not exceed sixty (60) days), and shall be provided to United within thirty (30) calendar days of United's report of its findings. United shall approve or disapprove the initial corrective action plan within thirty (30) calendar days of receipt of the corrective action plan. Vendor shall implement the approved corrective action plan within the specified timeframes. In the event the corrective action plan is not implemented to the reasonable satisfaction of United, United may terminate this Agreement pursuant to Section 9.2. Any disputes regarding United's determination with respect to a deficiency and/or the adequacy of Vendor's corrective action plan may be resolved pursuant to Section 12.

7.6 **Government and Accrediting Agency Access to Records.** Federal, State and local government and accrediting agencies including, but not limited to, CMS, the United States Department of Health and Human Services, the Comptroller General, the National Committee for Quality Assurance ("NCQA"), or any other regulatory agencies, as applicable, or any of their authorized representatives, shall have the right to inspect, evaluate and audit, and United and Vendor are authorized to release, all information and records or copies of such within the possession of United or Vendor that are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to United or Vendor. The government and accrediting agencies audit and inspection rights shall exist for at least ten (10) years from the final date of the Agreement, the date of completion of any audit, or such other period as required by law, whichever is later. Said government agencies may also evaluate, through inspection or other means, the quality, appropriateness and timeliness of services provided under this Agreement and compliance herewith.

7.7 **Confidential Business Information.** The parties acknowledge that in the course of performing under this Agreement each party may learn or receive confidential and proprietary information, including without limitation trade secrets, business or organizational plans, customer lists, pricing, and underwriting information, concerning the other party or third parties to whom the other party has an obligation of confidentiality ("Confidential Information"). For purposes of this Agreement, Confidential Information shall include, but not be limited to, including without limitation trade secrets, know-how, data, materials, products, technology, information systems and access thereto, computer programs, algorithms, formulas, processes, ideas, specifications, manuals, business or organizational plans and methods, software, marketing plans, financial information, claims data, product and service information, pricing information, sales information, vendor, customer, provider or member information and lists, underwriting information and all other confidential or proprietary information disclosed or submitted, orally, in writing, or by any other media, whether or not such Confidential Information is designated as being confidential and which has not been publicly disclosed. Confidential Information may be in written, oral, visual, photographic, electronic, magnetic, or physical form. Confidential Information shall not include information that:

(a) was in the party's possession prior to receipt of Confidential Information from the other party and not otherwise subject to obligations of confidentiality;

(b) at the time of receipt by a party is in the public domain or which at any time thereafter comes into the public domain through no fault of, or through a source other, than the receiving party;

(c) the party develops independently and internally, without reference to Confidential Information, as evidenced by written records prepared prior to the Effective Date of this Agreement; or

(d) the party receives from a third party on a non-confidential basis from a source, which to the best of such party's knowledge after due inquiry, is not prohibited from discussing such information by a legal, contractual or fiduciary obligation.

Each party shall take all necessary steps to provide the maximum protection to the other party's Confidential Information and records. Each party agrees to take at least such precautions to protect the other party's Confidential Information as it takes to protect its own Confidential Information. The parties shall not utilize any Confidential Information belonging to the other party without the other party's prior written consent for any purpose other than performance under this Agreement. The parties also shall agree not to disclose Confidential Information, in whole or in part, to any third parties without the express prior written consent of the party to whom the information belongs, other than to employees, legal counsel, accountants and other representatives who: (a) have a need to know solely for the purpose of performance under this Agreement; and (b) have been bound by the confidentiality obligations set forth herein. The parties further agree that they will not disclose Confidential Information to anyone within their respective organizations other than those employees with a need to know and who have been informed of the party's obligations under this Agreement. The parties may disclose Confidential Information to their attorneys, accountants, or other agents ("Representatives"), but only if they need to know the Confidential Information as described above. The parties shall inform each Representative of the confidential and proprietary nature of the Confidential Information. Upon request and upon termination of this Agreement, a party in possession of any Confidential Information belonging to the other party shall either promptly return such Confidential Information to the other party or, if so directed by the other party, destroy the Confidential Information, without retaining copies except as required by law. Upon request, a party shall provide the other party with written certification that the party has returned and/or destroyed any and all copies of the other party's Confidential Information except as required by law. Each party shall retain sole ownership of its own Confidential Information.

7.8 **Required Disclosures.** The confidentiality obligations described herein will not restrict any disclosure required by order of a court or any government agency, provided that the party being ordered to disclose the information gives prompt notice to the other party of any such order and reasonably cooperates with the other party, at the other party's request and expense, to resist such order or to obtain a protective order.

7.9 **United Data.** If Vendor transmits, stores, or has access to any type of data of United, Vendor shall not attempt to de-encrypt, capture, reassemble (if sent in packets), transport or view such data except as may be strictly necessary to provide services under this Agreement. As between United and Vendor, United shall at all times remain the exclusive owner of such data. In the event Vendor transports any devices (for warranty, maintenance, destruction or other purposes) which contain United data, Vendor shall ensure all reasonable measures are taken to secure such devices so as to prevent any unauthorized disclosure while in transit and while at rest. Vendor shall also ensure that as soon as reasonably possible, such devices are destroyed or the information is permanently wiped/deleted, in all instances subject to any of United's records retention policies.

7.10 **Ownership of Information.** Except as otherwise expressly provided for in this Agreement:

(a) Each party shall retain all right, title, and interest in its intellectual property, trademarks, trade dress, copyright, patent and other proprietary rights. Each party shall retain all right, title and interest in its proprietary business information or work product that may be used in advertising or promoting Covered Services or that is related to other activities under this Agreement, including but not limited to trade secrets, computer software and applications, and any other proprietary business information or work product that is not available to the general public.

(b) Upon termination of this Agreement, each party will return to the other party all intellectual property and work product belonging to the other party and shall not retain copies of such data except as shall be necessary under applicable law.

7.11 **Vendor Software and Systems.** If Vendor grants United access to Vendor information systems or Vendor's information processing resources under this Agreement, such access does not include a license to use the software programs contained within the foregoing. Any license to the software programs contained within the foregoing shall be pursuant to a separate agreement between the parties. United shall not attempt to reverse engineer or otherwise obtain copies of the software programs contained in Vendor's information systems. This Agreement does not transfer United title of any ownership rights or rights in patents, copyrights, trademarks and trade secrets included in the foregoing.

7.12 This Section 7 shall survive any termination of the Agreement. The parties agree that should either party breach its obligations under this Section 7, money damages alone would be inadequate compensation. Accordingly, in addition to any other remedies available by law or in equity, a court of competent jurisdiction may also enjoin the disclosure or use of a party's Confidential Information.

SECTION 8
REGULATORY COMPLIANCE

8.1 **Laws, Regulations, Licensure.** Vendor shall maintain and shall, as applicable, require all Participating Providers and all health care professionals employed by or under contract with Vendor or a Participating Provider to maintain all federal, State and local licenses, certifications, permits, regulatory approvals and accreditations, without material restriction, that are required to provide the services Vendor and Vendor's employees or Providers are obligated to provide under this Agreement. Vendor shall comply, and, as applicable, shall require Participating Providers and health care professionals employed by or under contract with Vendor to comply, in all material respects, with all applicable State and federal, and local laws statutes and regulations in connection with the performance of their obligations under this Agreement.

Vendor shall notify United if a governmental authority notifies Vendor that it must be licensed as an insurer, health service plan, health maintenance organization, prepaid limited health services organization, or other type of licensed insurer to provide Covered Services. In such event, Vendor may cease providing the services that would subject Vendor to such licensure, unless Vendor and United can agree upon an amendment to this Agreement that would make such licensure unnecessary. Any such cessation of services shall be effective the earlier of the date required by the governmental authority or after at least sixty (60) days following prior written notice to United.

United shall maintain all federal, State and local licenses, certifications, permits, regulatory approvals and accreditations, without material restriction, that are required to perform the business and services contemplated by this Agreement, including the issuance of Benefit Plans, and shall comply, in all material respects, with all applicable State, federal and local laws and regulations.

8.2 **Regulatory Appendices.** Contract provisions that are necessary to comply with the legal or regulatory requirements of certain jurisdictions or regulatory agencies will be set forth in individual appendices attached to this Agreement and made a part hereof (each, an "Appendix" and collectively, the "Appendices"). Vendor shall comply and, as applicable, shall require Participating Providers to comply, with the applicable terms and conditions of such Appendices. In the event of a conflict between the provisions of the main body of this Agreement and an Appendix, the terms of the Appendix will control. Notwithstanding the foregoing, the parties agree that the terms of Exhibit D shall apply only to the extent that they are applicable to Vendor.

8.3 **HIPAA.** Vendor shall perform the functions of a Business Associate as defined by and set forth in HIPAA and pursuant to the applicable Exhibits attached to this Agreement.

8.4 **Regulatory Approval and Filing.** In the event that a party is required to file this Agreement with federal, State or local governmental authorities, each party shall be responsible for filing the Agreement with such authorities as required by any applicable law or regulation. If, following any such filing, the governmental authority requests changes to this Agreement, Vendor and United shall jointly discuss the response to the governmental authority. In the event any federal, State or local governmental authority requires a change to this Agreement that either

Vendor or United deems to be material, either party may request re-negotiation of the affected provisions of this Agreement pursuant to Section 13.7 of this Agreement.

8.5 **Delegation of Activities.** If required by law or applicable accreditation standards, the parties to this Agreement agree to enter into a written Delegation of Credentialing Addendum, attached hereto as Exhibit C and made a part hereof, and such other delegation addendums as applicable that provide for the delegation of activities from United to Vendor. The activities to be delegated may include, but are not limited to, credentialing and recredentialing, utilization management, claims payment and management, and quality improvement. Vendor agrees to cooperate with United's requirements for delegation, including but not limited to an annual delegation audit review. In compliance with the delegation and oversight obligations imposed on United under its contracts with state and/or federal regulatory agencies, the State and/or United reserves the right to revoke any functions or activities delegated to Vendor under this Agreement, if in the regulatory agency's and/or United's reasonable judgment Vendor's performance under this Agreement does not comply with United's obligations under its government contracts. This right shall be in addition to United's termination rights under this Agreement.

8.6 **Right to Approve, Suspend or Terminate Providers.** United retains the absolute right to approve or reject a provider for participation in any or all of its Benefit Plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate until such provider is credentialed. United shall promptly inform Vendor and Vendor shall then inform the affected provider of any denial, restriction or revocation of the provider's participation status in any or all of United's Benefit Plans as determined by United. United also retains the absolute right to terminate or suspend any Participating Providers from participation in any or all of its Benefit Plans. In no case shall this Section 8.6 be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

8.7 **Immunity.** Vendor and United agree that activities delegated to Vendor by United may be considered professional and quality review procedures and that both Vendor and United may be immune pursuant to the Health Care Quality Improvement Act (42 U.S.C. 11101, et seq., as may be amended from time to time), or other federal or State law, from any civil liability arising from the delegated activities. The parties agrees to maintain the confidentiality of any privileged information to the extent permitted by law, and to obtain the other party's prior written consent before disclosing privileged information to any third party, except as otherwise required by law.

SECTION 9
TERM; TERMINATION

9.1 **Term of Agreement.** This Agreement shall commence on the Effective Date and shall remain in effect for an initial term of one (1) year unless otherwise terminated pursuant to Section 9.2, including specifically, by either party without cause as set forth in Section 9.2(b). Thereafter, it this Agreement shall renew automatically renew for successive one-year terms unless otherwise terminated pursuant to Section 9.2.

9.2 **Termination of Agreement.** This Agreement may be terminated as provided below:

(a) By mutual written agreement of the parties; provided, however, that any termination may be subject to advanced written approval of the State regulatory authorities.

(b) By either party, with or without cause, upon at least ninety (90) days prior written notice to the other party; provided, however, that the effective date of such termination shall in no case be earlier than January 31, 2016;

(c) By either party, upon at least sixty (60) days prior written notice to the other party in the event of a material breach of this Agreement by the other party, except as provided in Sections 9.2(d) and 9.2(e) below, unless the material breach has been cured or a reasonable corrective action plan has been developed and approved by the other party, such approval not to be unreasonably withheld, before the end of the sixty (60) day notice period. Vendor's nonperformance under this Agreement due to failure of United to properly provide PHI, personal information or other information required under this Agreement shall neither constitute a breach of contract nor provide grounds for termination;

(d) By either party, immediately upon written notice to the other party in the event either party becomes insolvent or is adjudicated as a bankrupt entity, or its business comes into possession or control, even temporarily, of any trustee in bankruptcy, or a receiver is appointed for it, or it makes a general assignment for the benefit of creditors, unless the other party elects in writing to forego termination of this Agreement;

(e) By either party, immediately upon written notice to the other party, in the event of the other party's loss or suspension of material licensure, certification or other governmental authorization necessary to perform under this Agreement, or loss of insurance required by Section 10.2;

(f) Pursuant to Section 13.7 or 13.8;

(g) By either party, upon a change in control of Vendor or United (other than a change in control in which UnitedHealth Group Incorporated, directly or indirectly, holds more than 50% of the outstanding voting securities or other equity interests of United or in which the change in control of Vendor results in beneficial ownership and control of Vendor remaining with the then existing owners, directors, or officers) upon at least one hundred and eighty (180) days prior written notice to the other party;

(h) This Agreement shall automatically terminate upon cessation of operations of United or Vendor. Notice of cessation of operations shall be provided to the other party as soon as practical; or

(i) If required by a state or federal regulatory agency with jurisdiction over this Agreement.

Upon notice of termination of this Agreement given by one party to another, United shall pay all fees owed to Vendor under this Agreement and Vendor shall provide Covered Services until the effective date of the termination.

9.3 **Effect of Expiration or Termination.** Upon the expiration or termination of this Agreement, Vendor will cooperate with United and/or United's designee to transition the care and management of Covered Persons undergoing treatment on the date of expiration or termination. Vendor, United and/or United's designee will work together to transition business, medical, and management records to United or United's designee in a commercially reasonable manner that reflects the rights and obligations of all parties, including Vendor's need for ongoing access to such records.

9.4 **Notice to Covered Persons.** Upon notice of termination of this Agreement, United and/or Payor shall have the right to notify, at their own expense, Covered Persons of such termination. Vendor and United must review and consent to the form of any written notice to Covered Persons regarding such termination. Neither party shall unreasonably withhold its consent to such notices proposed by the other party.

9.5 **Continued Provision of Health Services After Termination.** Vendor agrees that in the event this Agreement is terminated, Vendor shall use commercially reasonable efforts to cause Participating Providers to continue to provide Covered Services to any Covered Persons undergoing treatment at the time of such termination until:

(a) the current episode of treatment is completed, or as to any Covered Persons confined in inpatient facilities on the date of such termination, until such Covered Persons are discharged;

(b) arrangements are completed for such Covered Persons to be transferred to another provider; or

(c) until thirty (30) days after the termination date of this Agreement.

Participating Providers shall be reimbursed in accordance with their Provider Agreement for all such services rendered subsequent to the termination of this Agreement. United shall reimburse Vendor for the costs associated with such services.

9.6 **Remedies for Breach.** Nothing in this Section 9, including the termination of this Agreement, shall be construed to limit the remedies available to Vendor or United at law or in equity for breach of either party's obligations under this Agreement.

SECTION 10
INSURANCE

10.1 **Participating Provider Insurance.** As applicable, Vendor shall require Participating Providers to procure and maintain malpractice and/or professional liability insurance equal to the prevailing community standard unless State law or regulation requires otherwise, or unless United provides notice in advance of implementation of other insurance requirements.

10.2 **Vendor Insurance.** Unless otherwise agreed to by the parties in writing, Vendor, at its sole cost and expense, shall procure and maintain the insurance or self-insurance programs in the minimum amounts set forth below. Any such self-insurance programs will include actuarially approved funding levels. Vendor will provide United evidence of such insurance upon request.

(a) Commercial general liability insurance coverage, including but not limited to errors and omissions, in the minimum amounts of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate for the policy year.

(b) Professional liability insurance coverage in the minimum amounts of ten million dollars ($10,000,000) per occurrence and ten million dollars ($10,000,000) aggregate for the policy year.

(c) As applicable, worker's compensation insurance coverage for Vendor employees in an amount and form meeting all applicable legal and regulatory requirements.

SECTION 11
INDEMNIFICATION

The parties shall each indemnify and hold the other harmless from and against any and all liabilities including but not limited to losses, penalties, fines, costs, damages, claims, causes of action, and expenses the other incurs, including reasonable attorneys' fees, arising out of the indemnifying party's (i) material breach of this Agreement; (ii) willful misconduct or reckless or grossly negligent act or omission related to or in connection with performance under this Agreement; or (iii) violation of applicable law.

SECTION 12
DISPUTE RESOLUTION

The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as (each, a "Dispute" and collectively, the "Disputes") including but not limited to all questions of arbitrability, and the existence, validity, scope or termination of the Agreement or any term thereof. If the parties are unable to resolve any such Dispute within sixty (60) days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to further pursue the Dispute, it shall thereafter be submitted, as set forth

below to mediation and then if necessary to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"), as they may be amended from time to time (see http://www.adr.org). **The parties agree that the arbitrator chosen by the parties shall be a subject matter expert in insurance law.** Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute shall refer the Dispute first to mediation and must initiate the mediation within one (1) year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum. Such mediation must be initiated within sixty (60) days of the date one party first gave written notice of the Dispute to the other party. An independent and impartial mediator jointly selected by the parties who is qualified by education, training, and experience to hear matters in the nature of the Dispute shall conduct the mediation under the then current Commercial Mediation Procedures of the AAA unless the mediator otherwise determines to use other rules and practices. The mediation shall be held in a mutually agreeable site and, unless otherwise agreed, the parties shall bear the cost of the mediation equally between them. Other than with respect to its occurrence or the failure to occur, the mediation shall be in all respects confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

If the parties are not able to resolve the Dispute through the mediation process described above within ninety (90) days of referring the matter to mediation, the Dispute shall be resolved through binding arbitration in accordance with the then current AAA Commercial Arbitration Rules. As determined by the mutual agreement of the parties, the Dispute shall be heard and determined by either: (a) an independent and impartial arbitrator jointly selected by the parties who is qualified by education, training, and experience to hear and determine matters in the nature of the Dispute; or (b) an arbitral panel consisting of three (3) arbitrators, each of whom shall be independent and impartial. In the event the parties mutually agree to have an arbitral panel, each party shall, within thirty (30) days after commencement of the arbitration, select one person to act as arbitrator. The two arbitrators so selected shall, within fifteen (15) days of their appointment, select a third arbitrator who shall serve as the chairperson of the arbitral panel. The arbitrators selected shall be qualified by education, training, and experience to hear and determine maters in the nature of the Dispute. If a party fails to appoint an arbitrator as provided herein, or if the arbitrators selected by the parties are unable or fail to agree upon a third arbitrator within twenty (20) days of their appointment, then that arbitrator shall be selected and appointed in accordance with the AAA Commercial Arbitration Rules. The arbitrator(s) shall be bound by and shall follow the then current ABA/AAA Rules of Ethics for Arbitrators.

Any arbitration proceeding under this Agreement shall be conducted in Louisiana. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement, and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief. The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof.

Unless otherwise agreed to by both parties, the parties expressly intend that any Dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the Dispute related to this Agreement. The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

In the event that any portion of this Section or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Section or Agreement. While the parties agree and intend that any arbitration pursuant to this Agreement is binding, in the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

Unless the parties agree otherwise, the parties, the arbitrator(s), and the AAA shall treat the dispute resolution proceedings provided for herein, any related disclosures, and the decisions of the arbitrator(s) as confidential, except in connection with judicial proceedings ancillary to the dispute resolution proceedings, such as a judicial challenge to, or enforcement of, the arbitral award, and unless otherwise required by law to protect a legal right of a party.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved through mediation and if necessary arbitration under and in accordance with this Section 12. While the mediation or arbitration provided for hereunder remains pending, the termination for breach will not take effect.

This Section 12 shall govern any Dispute related to the subject matter hereto between the parties arising before or after execution of this Agreement and shall survive any termination of this Agreement.

SECTION 13
MISCELLANEOUS

13.1 **Assignment; Change of Control.** Except as provided in this Section 13.1, neither party shall assign, sell, transfer, delegate or otherwise dispose of, whether voluntarily or involuntarily, by operation of law or otherwise, this Agreement or any of its rights or obligations under this Agreement without the prior written consent of the other party; provided, however, that a party may assign, sell, transfer, delegate or otherwise dispose of this Agreement or any of its rights or obligations under this Agreement without the prior written consent of the other party solely in connection with a change of control, including merger, consolidation, corporate reorganization, sale of all or substantially all of such party's assets or stock, spin-off, change of name or like event, wherein the assignee agrees in writing to be bound by all terms and conditions of this Agreement; provided, however, that such surviving corporation or acquirer shall assume all obligations of such party and shall display to the other party's reasonable satisfaction such party's ability to perform such obligations. Any purported assignment, sale, transfer, delegation or other disposition by a party, except as permitted herein, shall be null and void. Subject to the foregoing, this Agreement shall be binding upon and shall inure to the benefit of the parties and their respective successors and permitted assigns. Any assignment may be subject to prior approval by an applicable regulatory agency.

13.2 **Entire Agreement and Amendment.** This Agreement, which incorporates all exhibits, attachments, addenda, and appendices, constitutes the entire agreement between the parties in regard to its subject matter. This Agreement may be amended only by a written amendment executed by both parties, except that United may amend this Agreement unilaterally to comply with the requirements of State and federal regulatory authorities, subject to Sections 13.7 and 13.8, and shall give written notice to Vendor of such amendment and its effective date. The headings and titles within this Agreement are for convenience only and are not a part of this Agreement. Any amendment may be subject to prior approval by an applicable regulatory agency.

13.3 **Marketing; Advertising; Use of Names and Trademarks.** During the term of this Agreement, all parties shall have the right to designate and make public reference to Vendor by name in an accurate, factual manner, as the company providing, managing and/or arranging for the provision of Covered Services. Vendor shall have the right to make public reference to United by name in an accurate, factual manner, as the company for whom Vendor is providing, managing and/or arranging for the provision of Covered Services. Vendor and United shall not otherwise use the other's name, trademarks, or service marks without prior written approval. The parties mutually agree to provide, at a minimum, at least forty-eight (48) hours advance notice and opportunity to comment on all press releases, advertisements or other media statements and communications regarding this Agreement, the services provided hereunder or the business relationship between the parties. Vendor shall obtain United's written consent prior to any publication or use of such materials or communications. Nothing herein shall be construed to create a right or license to make copies of any copyrighted materials.

13.4 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of Louisiana, without regard to the conflicts of laws provisions thereof.

13.5 **Notices.** Any notice, demand, or communication required under this Agreement shall be in writing, except in cases in which this Agreement specifically permits electronic notice. Written or electronic notices shall be deemed to have been given when delivered in person, by electronic communication, or by facsimile; or, if delivered via overnight delivery on the next business day. Notices sent by first-class United States mail shall be deemed given three (3) business days from the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth below or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested. Each party shall provide the other with proper addresses, facsimile numbers and electronic mail addresses of all designees that should receive certain notices or communication instead of that party. The addresses and individuals to which notices are sent may be changed by proper notice in accordance with the procedures outlined in this Section.

If to Vendor:
March Vision Care Group, Incorporated
Attention: President and CEO
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

With a required copy to
March Vision Care Group, Incorporated
Attention: General Counsel
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

If to United:
UnitedHealthcare Community & State
Attn; Daniel Denton
First Center Office Plaza
26957 Northwestern Highway
Suite 400
Southfield, MI 48033

With a Copy To:
UnitedHealthcare Community & State
Attention: Katy L. Bonnstetter, Senior Associate General Counsel
9701 Data Park Drive/MN006-W800
Minnetonka, MN 55343

13.6 **Compliance with Laws.** Vendor and United shall comply, in all material respects, with all applicable laws and regulations. Vendor shall, as applicable, use commercially reasonable efforts to require all Participating Providers, subcontractors and employees to comply with this provision.

13.7 **Change in Law.** If any federal, State, or local law, rule, regulation, or policy or any interpretation thereof (including, without limitation, any court order or ruling) at any time during the term of this Agreement has a material and adverse effect on the ability of a party to receive the benefits it reasonably expects to obtain under this Agreement or renders it illegal for a party to continue to perform under this Agreement in a manner consistent with the parties' intent, then the parties to this Agreement shall negotiate in good faith to amend this Agreement to bring it into compliance, while at the same time preserving the economic expectations of the parties, to the greatest extent possible. If the parties are not able to agree on an amendment to this Agreement within sixty (60) days of one party notifying the other party of a compliance issue pursuant to this Section 13.7, either party shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party provided such notice is given within fifteen (15) days of the end of the sixty (60) day renegotiation period.

13.8 **Substantial Change.** Except as provided in Section 13.7, the parties may renegotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a Substantial Change, defined as:

(a) A significant reduction in the number, or change in the composition of, Covered Person enrollment;

(b) A change in, utilization or trends;

(c) A modification of an existing Benefit Plan;

(d) Development of a new Benefit Plan;

(e) Expansion of United's service area to a geographic area of the country not originally contemplated under this Agreement

(f) An increase in the applicable provider fee schedule; or

(g) Any other significant change.

The affected party must promptly notify the other party of the Substantial Change and its desire to renegotiate this Agreement. If a new agreement is not executed within sixty (60) days of the receipt of the renegotiation notice, the party adversely affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party provided such notice is given within fifteen (15) days of the end of the sixty (60) day renegotiation period.

13.9 **Excluded Individuals.** Neither Vendor nor United shall employ or contract with any individual or entity who is excluded from participation in Medicare or a state health care program or with an entity that employs or contracts with such an individual or entity.

13.10 **Financial Information.** As periodically requested by United, Vendor shall make available to United, or to a third-party auditor retained by United, financial or other information pertinent to Vendor's ability to meet its financial obligations under this Agreement.

13.11 **Non-waiver.** The failure of either party to insist upon the strict observance or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy. Nothing in this Agreement shall be considered waived

by either party unless the party claiming the waiver receives the waiver in writing signed by an authorized signatory. A waiver of one provision does not constitute a waiver of any other.

13.12 **Relationship Between Parties.** The relationship between the parties to this Agreement is solely that of independent contractors. Nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, partnership, agency, joint venture, association or any other form of separate legal entity or organization.

13.13 **Survival of Terms.** Any provisions of this Agreement that, by their nature, extend beyond the expiration or termination of this Agreement shall survive the termination of this Agreement and shall remain in effect until all such obligations are satisfied. Any provision of the attached exhibits to this Agreement that contemplates performance, observance, or enforcement subsequent to the termination of this Agreement shall survive termination and remain in full force and effect between the parties until such obligations are satisfied.

13.14 **No Third Party Beneficiaries.** This Agreement is intended solely for the benefit of the parties hereto and no third parties shall have any rights hereunder or interest herein except as explicitly provided herein.

13.15 **Force Majeure.** The obligations of a party under this Agreement, other than the payment of money, will be suspended for the duration of any force majeure applicable to that party. The term "force majeure" means any cause not reasonably within the control of the party claiming suspension, including, without limitation, an act of God; industrial disturbance; any mass viral, bacterial, or other microbial or biologic outbreak, including an epidemic or pandemic; war; riot; invasion; acts of a foreign enemy; terrorist action; weather-related disaster; earthquake; and governmental action. A party claiming suspension under this section shall use its best efforts to resume performance as soon as possible.

13.16 **Arm's Length Negotiations, etc.** The parties acknowledge that the terms of this Agreement are fair and reasonable, were negotiated at arm's length, and that they were given ample opportunity to review and consider this Agreement prior to execution.

13.17 **Representations and Warranties.** Vendor and United each represent and warrant that each of the following statements is true and correct as of the Effective Date of this Agreement:

(a) **Due Organization**. Such party is duly organized and validly existing under the laws of the jurisdiction of its organization and has all requisite power and authority to execute and deliver this Agreement and carry on its business as now being conducted by it, and is in good standing or duly registered with the appropriate authority in each jurisdiction in which the nature of business conducted therein by it requires it to be qualified therein to do business and the failure to so register or be in good standing would have a material adverse effect on the other party.

(b) **Authority**. Such party has taken all action necessary for the authorization, execution, delivery and performance of this Agreement. This Agreement has been duly executed and delivered by such party and, when executed by the other party, constitutes the valid and binding obligation of such party, enforceable in accordance with its terms, except as such enforcement may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or other laws of general application affecting enforcement of creditors' rights.

(c) **No Conflict**. Neither the execution nor delivery of this Agreement nor the consummation of the transactions contemplated by this Agreement, nor the fulfillment of or compliance with the terms and conditions of this Agreement will conflict with any law, order, judgment or decree applicable to such party or with such party's charter documents, or result in a breach of or constitute a default under or conflict with any material contract, agreement or instrument to which such party is a party or by which it or its properties are bound.

13.18 **Administrative Responsibilities.** United may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, a Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee. United will notify Vendor ninety (90) days prior to United's delegation of such activities.

13.19 **Participating Providers; Subcontractors.** Vendor shall ensure that all contracts with Participating Providers who provide Covered Services to Medicaid and Medicare Covered Persons are in writing, duly executed, and incorporate the necessary terms and conditions as required by CMS and the State. Vendor may subcontract some, but not all, of its administrative services obligations hereunder upon prior written approval of United which may be given via electronic mail or any other method of notice set forth in Section 13.5 of this Agreement; provided that, all subcontracts shall in writing, duly executed, and incorporate the necessary terms and conditions as required by the State. Notwithstanding any provision in this Agreement to the contrary, United approves Vendor's use of March Vision Care, Inc. as a pre-approved subcontractor of Vendor.

13.20 **Vendor Locations.** For any location(s) outside of the fifty (50) United States ("Offshore Locations"), Vendor shall obtain prior written approval from United before offshoring such activity. For any locations outside of the fifty (50) states where Vendor performs work related to the Agreement for United, Vendor shall comply with any and all offshoring requirements or restrictions, including any applicable security controls, as updated from time to time to comply with applicable law. At a minimum, Vendor shall maintain the following security controls:

(a) Vendor shall conduct either a SAS70 Type II Audit, a BS-7799 certification, or an ISO27001 certification at all Offshore Locations from which work is performed by Vendor related to the Agreement, and will provide the resulting audit reports to United. The audits or certifications will be conducted once annually, and each report will cover a

twelve (12) month term. The audit report will be issued to United no later than sixty (60) days after the audit is completed.

(b) Vendor shall conduct assessments of general control objectives, as defined by United. These objectives may be periodically updated by United, effective upon delivery to Vendor, to address additional services that Vendor will provide to United.

(c) Vendor will comply with all future BS-7799 regulations, ISO27001 standards, or that of its successor(s), as issued by the SEC and the Public Company Accounting Oversight Board, British Standards Institute (BSI), or International Standards Organization (ISO).

(d) In the event that Vendor's audit report does not meet United requirements, United may exercise its rights under Sections 7.4 and 7.5 of this Agreement. All costs associated with such audit(s) shall be paid by Vendor.

(e) At United's request, Vendor will provide a quarterly management representation letter reflecting any material changes in the environment utilized for the provided services.

13.21 **Exclusion of Damages, Remedies, and Waiver.** NEITHER PARTY WILL BE LIABLE TO THE OTHER FOR INDIRECT, CONSEQUENTIAL, SPECIAL, INCIDENTAL, OR PUNITIVE DAMAGES, EVEN IF SUCH DAMAGES WERE FORESEEABLE, PROVIDED THAT THIS EXCLUSION WILL NOT APPLY TO DAMAGES CAUSED BY A PARTY'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT, OR OTHERWISE PAYABLE FOR VIOLATION OF THE CONFIDENTIALITY OR INDEMNIFICATION SECTIONS IN THIS AGREEMENT. The remedies specified in this Agreement are cumulative and in addition to any remedies available at law or in equity.

13.22 **Severability.** The invalidity or unenforceability of any clause or provision hereof shall in no way affect the validity or enforceability of the remainder of this Agreement.

[SIGNATURE PAGE FOLLOWS. THIS AGREEMENT MAY BE EXECUTED IN COUNTERPARTS AND SENT VIA FACSIMILE.]

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date.

MARCH VISION CARE GROUP, INCORPORATED	**UNITEDHEALTHCARE OF LOUISIANA, INC.**
By _____	By _____
Print Name Glenville A. March, Jr. M.D.	Print Name Paul J. Balthazor
Print Title Secretary	Print Title CFO

Payments shall be made to:
MARCH VISION CARE GROUP, INCORPORATED
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

EXHIBITS APPLICABLE TO THIS AGREEMENT

Those Exhibits checked below shall apply to this Agreement. All Exhibits not checked have been intentionally omitted.

_X_ Exhibit A:	Compensation for Services
_X_ Exhibit B:	Services Addendum
_X_ Exhibit B-1:	Vision Services – Schedule of Benefits
_X_ Exhibit B-2:	Performance Level Standards
_X_ Exhibit C:	Delegation of Credentialing Addendum
_X__Exhibit D:	Louisiana Medicaid Program Regulatory Requirements Appendix
_X__Exhibit E:	Business Associate Addendum
_X__Exhibit F:	Security

EXHIBIT A
COMPENSATION FOR SERVICES

SECTION 1
COMPENSATION FOR VENDOR SERVICES

Vendor shall provide the services set forth in this Agreement for the products or programs set forth in the table below. For such services, United shall pay Vendor a services fee (each, a "Monthly Fee" and collectively, the "Monthly Fees") at the rate set forth in the table below.

Licensed Health Plan or Legal Entity	Program/Product	Service Area	Rate
UnitedHealthcare of Louisiana, Inc.	Louisiana Medicaid – Bayou Health – Under Age 21	Louisiana	[redacted] PMPM
UnitedHealthcare of Louisiana, Inc.	Louisiana Medicaid – Bayou Health – Age 21+	Louisiana	[redacted] PMPM

The scope of covered vision services for each program or product listed above is set forth on the attached Exhibit B-1 attached hereto. Other services are set forth on the attached Exhibit B attached hereto.

SECTION 2
PAYMENT TERMS

2.1 **Monthly Fee Due Date.** United shall pay all Monthly Fees on or before the 10th business day of the month of service. United shall calculate Monthly Fees using an estimate of the number of Covered Persons based on the then current information available to United for that month. United shall provide Vendor contemporaneously with the payment of the Monthly Fees electronic detail that relates to the capitation payments. United shall adjust a subsequent Monthly Fee to reflect the difference between the estimated and actual number of Covered Persons.

Settlement of each month's balances due between the parties shall occur within ninety (90) days after the end of the month in which the amount owed becomes known. Notwithstanding this requirement, any more specific settlement terms in this Agreement shall control, no matter if the settlement date is shorter or longer than that set forth above, as long as the due date is specified.

2.2 **Financial Responsibility for Covered Services.** Vendor shall process claims and submit to United a bi-weekly invoice and paid claims file that details claims paid on behalf of Covered Persons. United shall remit payment to Vendor within 5 business days based on the total invoice (in addition to the payment of Monthly Fees as set forth is Section 2.1 herein).

SECTION 3
COMPENSATION TO PROVIDERS

Participating Providers shall be paid for Covered Services rendered to Covered Persons in accordance with the terms of their participating provider agreement with Vendor.

EXHIBIT B
SERVICES ADDENDUM

THIS SERVICES ADDENDUM (this "Addendum") supplements and is made a part of the Administrative Services Agreement (the "Agreement") between **MARCH VISION CARE GROUP, INCORPORATED** ("Vendor") and **UNITEDHEALTHCARE OF LOUISIANA, INC.** ("United"). Vendor shall provide those certain administrative and other services related to the provision of Covered Services to Covered Persons as set forth below.

SECTION 1
DEFINITIONS

Unless otherwise defined in this Addendum, all capitalized terms shall be as defined in the Agreement.

1.1 **Covered Services:** The Vision Services for which a Covered Person is entitled to receive coverage from United or a Payor, pursuant to the terms of the Covered Person's Benefit Plan which describes the benefits available to Covered Persons. The Benefit Plan includes health care coverage that is sponsored, issued or administered by United.

1.2 **Medicare Advantage:** The Medicare Advantage managed care program under which Medicare Advantage benefits are offered through United.

1.3 **Participating Provider or Provider:** A licensed or otherwise appropriately qualified and credentialed vision professional or entity that has executed a Provider Agreement with Vendor, directly or through another entity, to provide Covered Services to Covered Persons

1.4 **Vision Services:** The eye examinations, glasses, contact lenses, replacement eyewear, and other vision care services included in the Covered Persons' Benefit Plans that are offered by United under each Medicaid or Medical Assistance Program/Product and Medicare Advantage Program/Product identified in Section 1 of Exhibit A.

SECTION 2
NETWORK MANAGEMENT

2.1 **Network Development.** Vendor shall arrange for Participating Providers to provide Covered Services to Covered Persons pursuant to this Addendum and the performance level standards set forth in Exhibit B-2, Performance Level Standards. United may recommend to Vendor that certain providers become Participating Providers. In no case shall this provision be construed to obligate Vendor to contract with or make use of any particular health care facility or professional. Vendor retains full and complete rights to terminate a Participating Provider's Provider Agreement with Vendor. Vendor makes no representations or guarantees regarding the continued availability of any Participating Provider. Vendor shall provide United with electronic access in a mutually agreeable format to a listing of Participating Providers that Vendor will update

monthly. In the event of termination of a Participating Provider, Vendor shall assist Covered Persons in transitioning to a new Participating Provider within a reasonable time, or as required by State, federal and/or local law. Any material changes to the composition of the provider network are subject to prior written notification to the State regulatory authorities.

2.2 **Geographic Access.** Upon United's written request, Vendor shall provide United with a current listing of Participating Providers. Vendor's Participating Provider network will be sufficient to ensure that all Covered Persons within the United Service Area (which refers to the geographic area within which United provides services for Benefit Plans) have reasonable access to Covered Services and in accordance with State and federal law availability and access requirements. In the event United reasonably determines that there are not sufficient Participating Providers to provide Covered Services to Covered Persons:

- United shall notify Vendor of the alleged deficiency;
- United and Vendor shall meet to discuss the alleged deficiency, and
- If appropriate, develop a mutually satisfactory plan of correction within thirty (30) days of such notice.
- United shall have the ability to unilaterally impose a plan of correction if the parties cannot develop a timely and mutually satisfactory plan of correction.

United shall notify Vendor in writing at least ninety (90) days prior to any modification of United's Service Area. Vendor shall use best efforts to arrange for Participating Providers in such expanded Service Area within ninety (90) days of receiving such notice, at which time the definition of Service Area in this Agreement shall include such expansion without further compliance with Section 13.2.

2.3 **Vendor's Provider Agreements and Manuals.** Vendor's network participation requirements shall be set forth in its Provider Agreement, operations manual, and/or credentialing and recredentialing plan, all of which shall be made available to United upon written request. Vendor must have a written agreement in effect with each Participating Provider and shall ensure that its Provider Agreements and related manuals comply with all applicable laws, regulations and accrediting agency standards. Vendor understands and agrees that Vendor and Participating Providers may be subject to United's administrative guide and/or provider manual for the provision of Vendor Services and Covered Services for any government program Benefit Plan. The Provider Agreements will require Providers to comply with all applicable obligations in this Agreement and ensure that Covered Persons have access to Participating Providers for the programs and/or products set forth in Exhibit A and will include a plan summary describing such programs and/or products. Vendor and United shall work together in good faith to address any concerns United has regarding the content of such agreements and manuals.

Vendor shall cooperate with and provide to United copies of the Provider Agreements and manuals that United is required to file or submit to regulators or for accreditation purposes and agrees to work with the regulators or administrators of such government-sponsored programs and United to address any regulatory concerns regarding the content of such agreements or manuals.

In the event Vendor intends to make any substantial changes to its Provider Agreements or manuals that would materially affect this Agreement or require filing or submission to United's regulators or the administrators of the government-sponsored programs, Vendor shall notify United of such proposed changes in advance of their effective dates. Vendor and United shall work together in good faith to resolve any concerns United may have about the proposed changes and to complete any filing or submission United is required to make.

2.4 **Right to Approve, Suspend, or Terminate Providers.** United retains the absolute right to approve, suspend or terminate a Provider for participation in any or all of its benefit plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate, until such provider is credentialed. United shall promptly inform Vendor who shall then inform the affected Provider of any denial, restriction or revocation of the provider's participation status in any or all of United's benefit plans as determined by United. In no case shall this Section 2.4 be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

2.5 **Discontinuing Use of a Participating Provider.** Vendor shall discontinue making referrals to or otherwise using a Provider to provide Covered Services to Covered Persons as follows:

(a) immediately upon expiration of the Cure Period as to a material breach; provided that, Vendor shall have sixty (60) days from the date it receives written notice from United identifying the Provider's conduct that violates a material term of this Agreement or Vendor 's agreement with the Provider to cure such defect (the "Cure Period");

(b) immediately upon Vendor 's receipt of written notice that the Provider's license or certification has been revoked, suspended or otherwise limited;

(c) immediately upon Vendor's receipt of written notice that the Provider's liability insurance has been revoked;

(d) immediately upon Vendor's receipt of written notice that the Provider has been sanctioned by CMS or the State; or

(e) immediately upon termination of the Provider's agreement with Vendor.

Vendor will notify United of Vendor's discontinued use of a Provider to permit United to comply with its obligations under federal or state law or state contract to notify the State and its Covered Persons of changes to provider networks. Vendor shall provide this notice at least thirty (30)

days prior to its discontinuation of a Provider. If thirty (30) days advance notice is not possible, the notice must be immediate. The parties agree and acknowledge that under no circumstance shall services to enrollees be disrupted. Vendor agrees to abide by all applicable laws and regulations relating to provider appeals of termination.

SECTION 3
CREDENTIALING AND RECREDENTIALING

3.1 **Participating Provider Credentialing**. Vendor shall establish and maintain a credentialing and re-credentialing process to which all professional Participating Providers shall be credentialed or re-credentialed in accordance with the Delegation of Credentialing Addendum, attached to the Agreement as Exhibit C. Upon United's written request, Vendor shall provide United with a copy of Vendor's credentialing process. Vendor's credentialing process shall comply with Exhibit C of this Agreement and the applicable requirements of the National Committee for Quality Assurance ("NCQA"), Joint Commission on Accreditation of Healthcare Organizations or another generally recognized accrediting agency ("Accrediting Agency"). The services performed by Vendor under the Delegation of Credentialing Addendum shall, as set forth therein, be pursuant to the monitoring, oversight and approval of United. With reasonable prior written notice and during normal business hours, United may conduct comprehensive onsite evaluation of Vendor's credentialing procedures. Additionally, Vendor shall immediately provide documentation to United related to any issue concerning quality of care or related to any investigation or inquiries by regulatory agencies of any Participating Provider.

SECTION 4
UTILIZATION MANAGEMENT

United is not delegating any utilization management functions to Vendor.

SECTION 5
CLAIMS ADMINISTRATION AND COVERAGE DISPUTES

5.1 **Claims Administration.** Vendor shall perform certain claims administration services for claims and capitation payments associated with Covered Services provided to Covered Persons as described in this Section 5. Vendor shall arrange for Participating Providers to submit claims for Covered Services to Vendor. Claims shall be paid in accordance with the terms and conditions of the Benefit Plan, the Provider Agreements, Vendor's agreements with Participating Providers, this Addendum, the Agreement, and any applicable State or federal requirements.

5.2 **Benefit Administration.** Vendor shall make initial determinations whether services and/or supplies requested by or on behalf of a Covered Person or for which a Covered Person has requested reimbursement are Covered Services.

United shall have the final, binding, and exclusive discretionary authority with regard to the payment of any claim.

With respect to Medicare Advantage Covered Persons, all decisions related to coverage may be reviewed by CMS, and the CMS decision upon review is final and binding. If CMS overturns a denial of payment of any claim for which Vendor has financial responsibility under this the Agreement, Vendor must pay except as otherwise provided by Section 5.4 of this Addendum. If Vendor determines that the claim includes services and/or supplies that are not Covered Services, Vendor shall notify the Covered Person about the lack of coverage and the Covered Person's rights under the Benefit Plan to appeal a denial of coverage.

5.3 **Covered Person Appeal and Grievance Process.** In the event of disputes with a Covered Person or Provider regarding coverage of Covered Services, Vendor shall refer the Covered Person or Provider to the appropriate appeal and grievance processes under the Covered Person's Benefit Plan. Vendor shall cooperate with United with respect to any such appeal or grievance processes. If requested by United, Vendor shall provide or arrange for the vision care services in dispute and United shall reimburse Vendor for the costs associated with such services. Vendor shall be compensated in accordance with this Agreement. The result of the Covered Person appeal and grievance process shall be binding on Vendor, unless Vendor notifies United that Vendor disagrees with such result within fifteen (15) business days after Vendor receives notice of the result. In such case, United or Payor may authorize coverage and pay for the provision of the services and/or supplies in dispute, and the parties shall proceed with the dispute resolution process described in Section 5.5 of this Addendum.

With respect to Medicare Advantage Covered Persons, all decisions related to coverage may be reviewed by CMS, and the CMS decision upon review is final and binding. If CMS overturns a denial of payment of any claim for which Vendor has financial responsibility under this Agreement, Vendor must pay the claim as a covered service except as otherwise provided by Section 5.5 of this Addendum.

5.4 **Medicare Advantage Covered Person Coverage for Discounted Retail Items.** In the event a Medicare Advantage Covered Person purchases a covered vision retail item, such as eyeware, that is a Covered Service from a Participating Provider at a price below Medicare Advantage Covered Person's benefit for such item, Vendor will reimburse Medicare Advantage Covered Person in full for the amount Medicare Advantage Covered Person actually paid for the retail item.

5.5 **Coverage Disputes between Vendor and United or a Payor Regarding Covered Persons.** In the event: (a) of a dispute between Vendor and United or a Payor regarding whether particular services and/or supplies for a Covered Person are Covered Services for which Vendor has financial responsibility; or (b) if United or a Payor enters into a settlement agreement with a Covered Person as a result of actual or threatened grievance, arbitration or litigation, and United or Payor and Vendor do not agree on financial liability for such services (collectively, a "Coverage Dispute"), the parties shall comply with the following Coverage Dispute resolution procedure:

(a) The Coverage Dispute shall be submitted to United's or the Payor's and Vendor's Medical Directors, or equivalent, for review.

(b) The Medical Directors shall issue their determination within seven (7) business days after submission and receipt of appropriate and necessary information.

(c) In the event there continues to be a Coverage Dispute after the Medical Directors' review, the parties shall submit the Coverage Dispute to the most senior executive at each organization, who shall issue their determination within seven (7) business days after submission.

(d) In the event there continues to be a Coverage Dispute, the affected parties shall resolve such dispute in accordance with Section 12 of the Agreement.

5.6 **Effect of Expiration or Termination.** When the Agreement expires or is terminated pursuant to Section 9.2 of the Agreement, the parties agree as follows:

Covered Persons Claims. Vendor is financially and administratively responsible for any claims for Covered Services provided prior to the expiration or termination date, even if the claim for such Covered Services is not received until after the expiration or termination date. The applicable terms of this Addendum, including Sections 5.1, 5.2, 5.3 and 5.4, apply to such claims.

Vendor is also financially and administratively responsible for any claims for Covered Services provided after the expiration or termination date if the claim is related to completing Covered Services that started prior to the expiration or termination date. For example, completing a crown or root canal that was started, beyond examination, x-rays and recommendations, before the expiration or termination date. Completing such Covered Services is included in the payments Vendor received prior to the expiration or termination date. The applicable terms of this Addendum, including Sections 5.1, 5.2, 5.3 and 5.4, apply to such claims.

Vendor is not financially or administratively responsible for any other claims for Covered Persons that are related to Covered Services provided after the expiration or termination date. Vendor shall promptly forward any claims it receives for post-expiration or post-termination date Covered Services for Covered Persons that are not Vendor's responsibility to United or United's designee in a manner consistent with any agreement reached pursuant to Section 9.3 of the Agreement.

SECTION 6
OTHER SERVICES

6.1 **General Services.** In addition to the services described herein, Vendor shall provide the following:

(a) **Reporting.** Vendor will provide United with the reports identified below regarding Covered Services. Vendor shall provide such reports to United no later than thirty (30) business days after the end of each month or calendar quarter, or as otherwise required by law, as appropriate.

(i) **Reporting Changes to Provider Network**. Vendor shall provide United, in a format specified by United, a monthly file of those Participating Providers either terminated from or added to Vendor's network to ensure that United can update its system appropriately or as required by statutes, laws, or regulations.

(ii) **Monthly and Quarterly Reporting**. Vendor shall provide its standard monthly and quarterly cumulative reports.

(iii) **Specialized Reporting**. Upon agreement of the parties and for an additional fee, Vendor shall provide, within a time period mutually agreed to by the parties, specialized reporting of data regarding Covered Services provided or authorized by Vendor.

(iv) **Ad Hoc Reporting**. Vendor and United agree that United may receive one ad hoc report at no additional cost. Additional requests, description of work, terms, schedules and rates shall be detailed and mutually agreed to by United and Vendor prior to commencement of the work. Vendor agrees to cooperate with United in preparing any encounter or other reports, including but not limited to, denial rate reports; claims audit reports; coordination of benefits collection from third parties reports; and any other reports that may be required by CMS. In the event CMS requirements change, the parties agree to negotiate in good faith any additional fees related to additional or different reporting requirements and any applicable State or federal regulatory agencies or CMS.

(b) As applicable, Vendor acknowledges that Medicare Advantage Benefit Plans are required by CMS to maintain a health information system that collects, analyzes and integrates all data reasonably necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality, and such other matters as CMS may require from time to time. Vendor hereby agrees to submit to United, upon written request, all data Vendor possesses that is necessary to meet CMS requirements for Medicare Advantage Covered Persons, if any. At a minimum, Vendor must provide the following reports upon request: Denial rate reports; aged claims reports; claims audit reports; coordination of benefits collection from third parties reports; and any other reports that may be required by CMS. In the event CMS requirements change, the parties agree to negotiate in good faith any additional fees related to additional or different reporting requirements.

(c) **Data Feed.** Vendor shall make commercially reasonable efforts to provide an electronic data feed of Participating Provider contract information required for basic service calls from Covered Persons serviced by United's systems such as Facets, Cosmos, UNET, and EPD. To the extent such method is achieved and is to be put into use, the parties agree to execute such amendments to this Agreement as are necessary to address legal requirements, including, but not limited to, those required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other concerns related to such transmission.

(d) **Surveying.** Vendor shall cooperate with United with respect to surveys of a sample of Covered Persons who have accessed Covered Services pursuant to the Agreement and/or Participating Providers to assess satisfaction with Vendor. Vendor shall work with United to develop and administer such surveys. If areas of dissatisfaction are identified as a result of such surveys, Vendor will develop commercially reasonable corrective strategies for mutually identified areas of concern.

6.2 **Quality Management.** United shall establish and maintain its own quality management program and such other assessment and improvement programs it determines appropriate. Vendor shall cooperate with, and shall use reasonable efforts to ensure Participating Providers cooperate with, any such reasonable and similar programs established or required by United or a Payor, CMS or any applicable State regulatory agency.

6.3 **Provider Agreements and Manuals.** Upon written request, Vendor shall provide United a copy of Vendor's then current generic written participation agreement that Vendor uses when contracting with Providers and any related provider manuals. Any Provider Agreements/templates used by Vendor must be preapproved by United. Vendor's Provider Agreements will require Providers to comply with the applicable obligations in this Agreement. Vendor and United shall work together in good faith to address any concerns United has regarding the content of such agreements or manuals.

Vendor shall ensure that its Provider Agreements and related manuals comply with applicable laws, regulations and Accrediting Agency standards. Vendor shall cooperate with and provide to United copies of the Provider Agreements and manuals that United is required to file or submit to regulators or for accreditation purposes.

In the event Vendor intends to make any substantial changes to its Provider Agreements or manuals that would materially affect this Agreement or require filing or submission to United's regulators or Accrediting Agencies, Vendor shall notify United of such proposed changes before they are effective and Vendor and United shall work together in good faith to resolve any concerns United may have about the proposed changes and to complete any filing or submission United is required to make.

EXHIBIT B-1
VISION SERVICES – SCHEDULE OF BENEFITS

SECTION 1
GENERAL

This Schedule lists the vision care benefits to which Covered Persons of United are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. This Schedule forms a part of the Agreement to which it is attached.

When Covered Services are provided by Participating Providers, benefits appearing in the first column below are applicable subject to any Copayments as stated below.

SECTION 2
PLAN BENEFITS

VISION CARE SERVICES

	PARTICIPATING PROVIDER BENEFIT	NON-PARTICIPATING PROVIDER BENEFIT
Eye Examination	See Attachment 1	Not Covered
Medically Necessary Services	See Attachment 1	Not Covered

VISION CARE MATERIALS (Lenses & Frames)

	PARTICIPATING PROVIDER BENEFIT	NON-PARTICIPATING PROVIDER BENEFIT
Lenses		
Single Vision	See Attachment 1	Not Covered
Bifocal	See Attachment 1	Not Covered
Trifocal	See Attachment 1	Not Covered
Lenticular	See Attachment 1	Not Covered

	PARTICIPATING PROVIDER BENEFIT	NON-PARTICIPATING PROVIDER BENEFIT
Frames	See Attachment 1.	Not Covered

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;

- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

VISION CARE MATERIALS (Contact Lenses)

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Participating Provider. Prior review and approval by Vendor are not required for Covered Person to be eligible for Necessary Contact Lenses.

	PARTICIPATING PROVIDER BENEFIT	NON-PARTICIPATING PROVIDER BENEFIT
Contact Lenses	See Attachment 1	Not Covered

COPAYMENT

The benefits described above are available to each Covered Person from any Participating Provider at no cost to the Covered Person, with the exception of any applicable Copayment as described below.

Louisiana Medicaid – Bayou Health
There shall be no Copayment payable by the Covered Person to the Participating Provider at the time services are rendered

EXCLUSIONS AND LIMITATIONS OF BENEFITS

PATIENT OPTIONS
This Plan is designed to cover visual needs rather than cosmetic materials. Eye wear may not be upgraded for cosmetic purposes, allowing the recipient to pay the remaining difference. Members are eligible only to receive Covered eye wear as outlined on Attachment 1 or the Louisiana Medicaid Program guidelines.

NOT COVERED

There are no benefits through this Agreement for services or materials connected with:

- Surgical treatment of the eyes;

- Medication;

- Medical treatment of the eyes, other than services covered as part of the Additional Benefit – Primary Eyecare;

- Any eye examination or any corrective eyewear required by an employer as a condition of employment;

- Refractive surgery, such as, but not limited to, LASIK, LASEK, RK and PRK.

- Corrective vision treatment of an experimental nature.

- Any other services listed under Non-Covered Services on Attachment 1

THE VENDOR MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF THE VENDOR'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

SECTION 3
ADDITIONAL BENEFIT - PRIMARY EYECARE

Primary Eyecare is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the plan, Participating Providers provide treatment and management of urgent and follow-up services. Primary Eyecare also involves management of conditions which require monitoring to prevent future vision loss.

The Participating Provider is responsible for advising and educating patients on matters of general health and prevention of ocular, as well as systemic disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Participating Provider as a Primary Eyecare Professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

SYMPTOMS
Examples of symptoms which may result in a patient seeking services on an urgent basis under the Primary Eyecare Offering include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS
Examples of conditions which may require management under the Primary Eyecare Offering, include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- macular degeneration
- corneal dystrophy
- corneal abrasion

- cataract
- blepharitis
- pink-eye
- sty

PROCEDURES FOR OBTAINING PRIMARY EYECARE SERVICES

1. To obtain Primary Eyecare Services, the Covered Person contacts a Participating Provider's office and makes an appointment.

2. If urgent care is necessary, the Covered Person may be seen by a Participating Provider immediately.

3. The Covered Person pays the applicable Copayment to the Participating Provider at the time of each Primary Eyecare office visit.

4. When the Participating Provider has completed the services, he will submit the claim to Vendor. Vendor will pay the Participating Provider directly according to Vendor's agreement with the Participating Provider.

COPAYMENT

The benefits described herein are available to each Covered Person from any Participating Provider at no cost to the Covered Person, with the exception of any applicable Copayment as described below.

Louisiana Medicaid – Bayou Health

There shall be no Copayment payable by the Covered Person to the Participating Provider at the time services are rendered

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Primary Eyecare Offering is designed to cover Primary Eyecare services only from Vendor's Participating Providers. There is no coverage provided under the Offering for the following:

1. Costs associated with securing materials such as lenses and frames.
2. Orthoptics or vision training and any associated supplemental testing.
3. Surgical or pathological treatment.
4. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.
5. Medication.
6. Pre and post-operative services.

REFERRALS BY THE PARTICIPATING PROVIDER

The Participating Provider will refer the patient to another doctor under the following conditions:

1. If the patient requires additional services which are covered by the Primary Eyecare Offering but are not provided in his office, the Participating Provider will refer the patient to United or to the patient's primary care physician.

2. If the patient requires services beyond the scope of the Primary Eyecare Offering, the Participating Provider will refer the patient back to United or to the patient's primary care physician.

3. If the patient requires emergency services beyond the scope of the Primary Eyecare Offering, the Participating Provider will make a "STAT" (emergency) referral by calling 911 or directing the patient to the nearest emergency room.

DEFINITIONS

Blepharitis - Inflammation of the eyelids.

Cataract - A cloudiness of the lens of the eye obstructing vision.

Conjunctiva - The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eyeball.

Corneal Abrasion - Irritation of the transparent part of the coat of the eyeball.

Corneal Dystrophy - A disorder involving nervous and muscular tissue of the transparent part of the coat of the eyeball.

Diplopia - The observance by a person of seeing double images of an object.

Eye Muscle Dysfunction - A disorder or weakness of the muscles that control eye movement.

Glaucoma - A disease of the eye marked by increased pressure within the eyeball which causes damage to the optic disc and gradual loss of vision.

Flashes or Floaters - The observance by a person of seeing flashing lights and/or spots.

Macula - A small, yellowish area lying slightly lateral to the center of the retina that constitutes the region of maximum visual acuity.

Macular Degeneration - Degeneration of the macula.

Ocular - Of or relating to the eye or the eyesight.

Ocular Hypertension - Unusually high blood pressure within the eye.

Ocular Conditions - Any condition, problem, or complaint relating to the eyes or eyesight.

Ocular Trauma - A forceful injury to the eye due to a foreign object, e.g., fist, baseball,

racquetball, auto accident, etc.

Pink-eye - An acute, highly contagious, conjunctivitis (inflammation of the conjunctiva).

Retinal Nevus - A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.

Sty - An inflamed swelling of the fatty material at the margin of the eyelid.

Systemic Condition - Any condition or problem relating to a person's general health.

Transient Loss of Vision - Temporary loss of vision.

Exhibit B-1, Attachment 1
UHC Louisiana - Covered Benefits (Bayou Health)

Benefit	Medicaid - Under age 21	Medicaid - age 21 and over
Routine Exam	1 service date every calendar year	1 service date every two calendar years.
Replacement Exam	Covered as needed when it is not possible to return to or obtain the prescription from the previous provider and criteria for replacement lenses have been met.	Not covered.
Standard Frame	1 unit every calendar year ▪ Metal or plastic frames. The frames must be sturdy and nonflammable. Both the metal and non-metal frames must carry at least a one year manufacturer's warranty.	Up to $100 allowance toward one pair of frames & lenses every two calendar years.
Deluxe Frame	1 unit every calendar year (in lieu of Standard Frame) when medically necessary and documented in Member's chart. Examples include ▪ Has a wide nose bridge due to a medical syndrome. ▪ Has a small head and regular frames would not fit.	Up to $100 allowance toward one pair of frames and lenses every two calendar years
Lenses (Single Vision and Bifocal/trifocal)	2 units (1 pair) every calendar year ▪ Regular single vision lenses are covered if the following criterion is met. ▪ At least one lens must exceed +1.00 sphere, -0.50 sphere or +/- -0.50 plano cylinder ▪ Regular bifocal/trifocal lenses are covered when medically necessary and documented in the Member's chart. ▪ Polycarbonate lenses are covered when medically necessary and documented in the Member's chart. Examples include: ▪ Has seizures and may be prone to fall ▪ Blind in one eye	Up to $100 allowance toward one pair of frames and lenses every two calendar years
Contact Lenses	2 units (1 lens per eye) every calendar year in lieu of eyeglasses; requires prior confirmation ▪ Medically necessary contact lenses are covered when the following criterion is met. ▪ An unusual eye disease or disorder exists which is not correctable with eyeglasses; ▪ Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear; ▪ Irregular cornea or irregular astigmatism (does not apply if the recipient has had previous refractive surgery); ▪ Significant, symptomatic anisometropia; or ▪ Aphakia (Post Surgical).	Up to $105 allowance in lieu of glasses for fitting/evaluation, contacts (disposable contacts up to four boxes, depending on prescription and plan selected) and up to two follow-up visits.
Replacement Frames	Covered as needed. ▪ Billing for the fourth and subsequent frame must have documentation attached justifying the need for more than three pair of eye wear per calendar year ▪ Acceptable documentation includes but is not limited to: ▪ Documentation which shows the necessity of changing the prescription for the eye wear more than three time in the calendar year. ▪ Copies of the different prescriptions for eyeglasses which were written within the calendar year. ▪ Providers may dispense a replacement frame to a complete eyeglass which a recipient already owns.	Not covered
Replacement Lenses (including contact lenses)	Covered as needed. ▪ Billing for more than 4 replacement lenses must have documentation attached justifying the need for more than four replacement lenses per calendar year ▪ Acceptable documentation includes but is not limited to: ▪ Documentation which shows the necessity of changing the prescription for the eye wear more than three time in the calendar year. ▪ Copies of the different prescriptions for eyeglasses which were written within the calendar year	Not covered
Necessary Medical Services	Covered as needed within the scope of licensure for an optometrist.	Covered as needed within the scope of licensure for an optometrist

Non-Covered Services	Services not mentioned above are not administered by MARCH, including, but not limited to ▪ Surgical eye care ▪ Low vision aids ▪ Tinted Lenses ▪ Hi Index Lenses ▪ Polarized Lenses ▪ "Spare" or "back-up" eyewear ▪ Eye wear upgrades for cosmetic purposes	Services not mentioned above are not administered by MARCH, including, but not limited to: ▪ Surgical eye care ▪ Low vision aids ▪ "Spare" or "back-up" eyewear ▪ Eye wear upgrades for cosmetic purposes
Benefit Plan ID	LABYHP	LABYHP + Age evaluation

Source: LOUISIANA MEDICAID PROGRAM ISSUED: 04/21/11
CHAPTER 46: VISION (EYE-WEAR) SERVICES
SECTION 46.1: COVERED SERVICES

EXHIBIT B-2
PERFORMANCE LEVEL STANDARDS

THESE PERFORMANCE LEVEL STANDARDS (these "Performance Standards") shall govern the performance of the services that March Vision Care Group, Incorporated ("March") renders on behalf of UnitedHealthcare of Louisiana, Inc. ("United") pursuant to that certain Administrative Services Agreement entered into between March and United, effective February 1, 2015(the "Agreement").

Capitalized terms not otherwise defined in these Performance Standards shall have the meaning ascribed to them in the Agreement.

SECTION 1
INTRODUCTION

United contracts with the state and federal government to provide health care services and support to beneficiaries of government-sponsored health programs. Under these agreements, United has obligations to and responsibilities for services to beneficiaries, providers and its government customers. United relies on the services and resources of March to provide vision services to Covered Persons, develop a vision provider network to meet state accessibility and network performance standards and achieve competitive parity or advantage with other government program plans.

SECTION 2
PURPOSE

The purpose of these Performance Standards is to set forth additional operational detail regarding the performance requirements, expectations and responsibilities for March regarding the services March performs on behalf of United. All such requirements, expectations and responsibilities shall constitute policies and procedures that March agrees to observe in performing its obligations under the Agreement.

SECTION 3
STANDARD SERVICES TO BE DELIVERED

March shall provide United a spectrum of vision services as described in the Agreement. In performance of these services, March will manage the confirmation of benefits and eligibility and all vision claims processing. March will perform network management services, including provider recruitment, provider education and training and provider credentialing. March shall maintain a network of vision providers that meet state and federal accessibility and network performance standards, and achieves competitive parity or advantage with other government program plans in the applicable service area.

SECTION 4
CHANGES TO ANY SERVICES DELIVERED

United's contract with state and federal governments allows United to provide additional treatment services to Covered Persons that may not be specifically mentioned within the Covered Person's Benefit Plan. Therefore, United may, from time to time, request from March certain non-standard vision services for Covered Persons if the services are in the best interest of the Covered Person. March agrees to use its best efforts to comply with such requests.

The parties may also determine that a change to the delivery of services set forth in the Agreement and these Performance Standards is necessary. Any additional State accessibility and network performance standards that apply to March's development of the network other than detailed in these Performance Standards shall be attached as Schedule A to these Performance Standards. Either party may propose changes to the scope, nature or time schedules of any services being performed under these Performance Standards or the Agreement; provided, however that both parties mutually agree to the proposed changes, including any changes to metrics reporting or operational guidelines. All changes will be subject to approval by both parties.

SECTION 5
UNITED RESPONSIBILTIES

United shall continuously assess March's service performance and reporting metrics, as set forth in these Performance Standards to identify trends and opportunities for process improvement. United will schedule monthly meetings with March to review the metrics described in these Performance Standards or Schedule A.

United will actively seek and provide feedback concerning issues/problems that arise in the delivery of services to Covered Persons and will identify one national point of contact to act as the primary liaison between United and March.

SECTION 6
PERFORMANCE AND REPORTING

The most critical aspect of these Performance Standards is the monitoring and measuring of March's service level performance. All key services provided to Covered Persons must be carefully measured and monitored by March and the results analyzed and reported to United as set forth in Schedule A to these Performance Standards. All benchmarks, targets and metrics, as well as reporting timeframes are described in Schedule A.

Service performance levels must be reviewed monthly by both United and March. Any problems that might arise must be addressed in accordance with the terms set forth in Schedule A.

In the event that, during an audit of United, whether internal or external, or any other time during the term of the Agreement, the internal auditing body, state, or a regulatory agency identifies a

deficiency(ies) in any of the performance metrics or reporting requirements set forth in these Performance Standards, United shall notify March of the identified deficiency(ies) within 7 calendar days or as soon as possible. The parties agree and acknowledge that any such deficiency(ies) identified will be resolved according to the audit and/or corrective action plans in the plan requirements set forth in the Agreement.

SECTION 7
TERM; TERMINATION

These Performance Standards are coterminous with the Agreement and shall expire or terminate on even date therewith.

SECTION 8
POLICIES AND PROCEDURES

March shall develop and maintain throughout the term of this agreement, and make available upon request by United, policies and procedures that document and define March's ability to fully comply with all services delegated to March through the Agreement and demonstrate compliance with any state regulatory requirements. Examples of functions or responsibilities to be supported by March policies and procedures include, but are not limited to:

- Maintaining an accurate list of the United Medicaid/Medicare Plans and the functions provided for each Plan with which March has a contractual or other arrangement, along with providing contracts or other such documents defining the roles and responsibilities of each party
- Network access and adequacy in accordance with any state/federal access requirements (at a minimum)
- Provider education and training materials, such as provider manuals and web based informational materials, that clearly identify compliance requirements for United membership, and the ability to verify that providers have accessed the education and training materials
- Provider contracts, in particular the inclusion of contract language in all provider agreements supporting United membership which at a minimum contain the applicable state Medicaid and Medicare Advantage regulatory appendix and any other required state/federal contract language requirements
- Provider terminations, including specificity to which March communicates terminations to the plan, and adherence to any state/federal requirements as it relates to member notifications
- Credentialing and recredentialing meeting all state/federal regulatory requirements
- Generally, policies that address meeting state/federal requirements for functions such as identifying and reporting fraud, waste and abuse, record retention, confidentiality, non-discrimination, information management, protection of protected health information (PHI), HIPAA compliance, privacy and security

SECTION 9
PENALTIES & LIQUIDATED DAMAGES

March shall achieve the performance level standards and reporting contained in Schedule A attached hereto. Failure to achieve these standards will result in the assessment of a penalty equal to one percent (1.0%) of such month's capitation payment to March by United for the applicable Program or Product. United shall request in writing from March payment for such penalty and March shall pay such penalty within 30 days of receipt of such invoice. Notwithstanding the foregoing, any failure to achieve the standards and reporting will not result in a penalty being imposed on March when such failure is caused or contributed to by the actions or inactions of United.

SCHEDULE A
PERFORMANCE AND REPORTING SPECIFICATIONS

Table of Contents

SECTION 1
PRODUCTS, SERVICES AND PROGRAMS

Product Description	Service Description
Louisiana Medicaid – Bayou Health	Vision Services

SECTION 2
CHANGES TO SERVICES DELIVERED

At times, it may be necessary for either United or March to require or request a change to the services being delivered. All changes to the delivery of any services must be conducted according to the following process:

Either party must submit proposed changes to the scope, nature or time schedule of any services being performed, in writing, to one identified, main point of contact at either organization. Accordingly, either the United or March contact shall reply in writing (email or letter), within ten (10) business days, agreeing to the proposed changes or declining the proposed changes. Note: Contractual or Regulatory required services cannot be declined by either party. If either party disagrees with the proposed changes, United and March shall discuss the changes and come to an agreement on the changes within ten (10) business days. All changes mutually agreed upon will then be documented in writing and finalized with an amendment signed by both parties to either this Schedule A or to these Performance Standards.

SECTION 3
PROBLEM MANAGEMENT

3.1 **Definitions.** For the purposes of these Performance Standards and this Schedule A, the following terms shall have the meanings set forth below.

Problem shall mean any issue or concern regarding services provided to a Covered Person; any deficiency in meeting any of the outlined service metrics; or any shortfall in meeting any of the network adequacy requirements.

Escalation Process shall mean issues or concerns that arise that cannot be handled by line personnel in the normal process (i.e., via direct discussion or email) and therefore must be escalated to one management level contact at March or United, who in turn, must investigate the issue, ensure a mutual resolution to the issue, and relay the final outcome to all parties involved. Escalated service issues that arise will be directed to one point of contact at United, and will be resolved via one point of contact at March.

3.2 **Problem Management Response Times.** Below are the expected response times for specific issues reported by United:

- Concerns involving cases of an urgent nature shall be responded to by March within four (4) hours.
- Concerns general in nature shall be responded to by March within two (2) business days.
- Metrics that are out of compliance with an established target will be identified in an executive summary to the performance level standards report. The United and March group reviewing the report will identify opportunities to track and trend specific metrics and will establish when a corrective action plan is warranted based on two (2) or more quarter's performance falling outside the identified targeted performance.

SECTION 4
CLAIMS AND ENCOUNTERS PERFORMANCE AND REPORTING

March shall comply with the performance metrics and reporting requirements related to claims and encounters as set forth in the table below. With the exception of monthly reporting dates for actual encounters, which may vary by deliverable to a particular health plan, any other monthly reporting shall be provided by the tenth (10^{th}) day of the following month. Any quarterly reporting shall be provided within twenty (20) calendar days after the end of each quarter.

Metric	Metric Description	Measurement	Expected Value	Frequency
Total Claims Received	Total number of claims received for services provided to Medicare Medicaid members	# of total claims received	As Reported	Monthly, Annual Trending
EDI claims Usage	Number of claims received, and percentage of total electronic claims, that originated from an electronic, non-paper format	# of electronic claims % of total claims received electronically	As Reported	Monthly, Annual Trending
EDI Claims Rejection	Number of claims submitted, and percentage of total electronic claims, that are rejected and require manual intervention	# of electronic claims rejected % of total electronic claims received that are rejected	As Reported	Monthly, Annual Trending
Manual Claims Usage	Number of claims processed, and percentage of total claims, that originated from a paper format	# of manual claims received % of total claims received manually	As Reported	Monthly, Annual Trending

Total # of claims adjudicated	Number and dollar amount of claims for which a determination of benefits has been made for services provided to Medicare/ Medicaid members	# of claims successfully adjudicated $ amount of adjudicated claims	As Reported	Monthly, Annual Trending
Auto-Adjudication of claims	The total Number of claims and the total dollar amount of claims automatically adjudicated (i.e., individual claim did not require any direct manual intervention in determining claim benefit) and the percentage of claims auto adjudicated relative to the number of total claims processed	# of claims auto-adjudicated $ amount of claims auto-adjudicated % of total claims auto-Adjudicated	As Reported	Monthly, Annual Trending
Manual Adjudication of Claims	Claims adjudicated through direct manual intervention in determining the claim benefit	# of claims manually adjudicated $ amount of claims manually adjudicated	As Reported	Monthly, Annual Trending

Claims Adjudication Financial Accuracy	Based on a random sample of claims adjudicated, calculate the percentage of claims with no financials errors, including correct determination of coinsurances, deductibles, maximum out-of-pocket expenses, COB, and usual and customary calculations	% of claims without financial errors	90% of total claims processed over measurement period will be paid correctly – 3% sampling of claims	Quarterly, Annual Trending
Claims Adjudication Clerical Accuracy	Based on a random sample of claims adjudicated, calculate the percentage of claims with no clerical errors, including place of service, disallow codes, provider, date claim received, diagnosis, procedure, patient name and date of service	% of claims paid without clerical errors	90% of total claims processed over measurement period will be free of clerical errors – 3% sampling of claims	Quarterly, Annual Trending
Total Claims Paid	Total number and dollar amount of claims for which payment was made in the current month	# of claims $ total claims paid	As Reported	Monthly, Annual Trending
Average $ amount per claim	Total dollar amount of claims paid divided by total number of claims paid	Average $ amount per claim	As Reported	Monthly, Annual Trending
Highest claim paid	Dollar amount of Claim with highest dollar amount paid	$ highest claim paid	As Reported	Monthly, Annual Trending

Total Interest Paid	Interest paid on claims	# of claims with interest paid $ amount of Interest paid	As Reported	Monthly, Annual Trending
Interest Paid as % of total	Interest $ amount as total of the claims payment made	% total payment that accounts for interest paid	As Reported	Monthly, Annual Trending
Claim Turnaround Time	Time, in number of days, between receipt of claims and payment and/or mailing of EOB to provider or member, for clean claims.	# of days	At least **90%** of all clean claims will be processed or paid within **15** business days of the date of receipt* At least 99% of all clean claims will be processed or paid within **30** calendar days of the date of receipt	Monthly, Annual Trending
Correctly Formatted Encounter File	Report in required Proprietary Format Within Expected State Time Frames	Yes/No compliant with requirements	Correct format, delivered on time	Monthly by the 10th
Encounter Volume	Total # of encounters and dollar amount submitted to the state	# of encounters $ total encounters amount	As Reported	Monthly, Annual Trending

*Date of receipt is defined as the date that March receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

SECTION 5
OPERATIONAL/PROVIDER NETWORK PERFORMANCE AND REPORTING

March shall comply with the performance metrics and reporting requirements related to provider network services as set forth in the table below. Monthly reporting shall be provided by the tenth (10^{th}) day of the following month. Quarterly reporting shall be provided within twenty (20) calendar days after the end of each quarter.

Metric	Metric Description	Measurement	Expected Value	Frequency
Average number of members per provider (Network Adequacy)	The ratio between member and provider, calculated by the total number of current Medicare/Medicaid members divided by the number of providers currently accepting Medicare/Medicaid	# of total members # of total Providers Average Member per provider	1 Provider per every 2,500 Covered Persons	Quarterly, Annual Trending
Average miles and/or driving time between member and provider (Network Adequacy)	Average distance in miles between existing Medicare/Medicaid members and Providers currently accepting Medicare/Medicaid members	# of average miles between members and providers (as evidenced through Geo Access Reporting)	60 miles for 75% of the population 90 miles for 100% of the population	Quarterly, Annual Trending
Provider Demographic Accuracy	Calculate the percentage of Providers with no errors based upon key fields (License numbers, address, Medicaid ID, etc.)	% accuracy	As reported	Quarterly
Provider File Health Plan Submission (PV46)	For Plan network submission to the state and for encounter submission, the Provider File will include all state required Provider demographic data.		As Reported	Weekly

Provider Termination – Member Report	When a provider terminates with March – March will send a report of members that utilized that provider within the past 12 months	Report includes Bayou Health member utilization and demographic information	As reported	Ad Hoc

5.1 **Provider Materials.** Vendor shall comply with the performance metrics and reporting requirements related to provider materials and provider training as specified below.

Category	Metric	Requirement	Reporting Frequency
Provider Agreement	Submission of provider agreement templates and revisions	Vendor will submit to United annually or whenever updated - copies of all provider agreement templates which must comply with all LA State/Bayou Health requirements.	Annual, Ad Hoc
Provider Manual	Submission of provider manual and revisions	Vendor will submit to United annually or whenever updated - its Provider Manual which must comply with all LA State/Bayou Health requirements. Any proposed revisions may be released only after approval has been given.	Annual, Ad Hoc

SECTION 6
CREDENTIALING AND RECREDENTIALING

March shall comply with the performance metrics and reporting requirements related to credentialing and recredentialing as specified below.

Metric	Metric Description	Requirement	Reporting Frequency
Re-credentialing Frequency	Length of time between when a Provider was last credentialed to when the Provider is next credentialed	Once every 3 years upon initial credentialing date	N/A

New Application and Re-credentialing Turn-Around-Time (TAT)	Length of time from the initiation to the completion of the credentialing process for each Provider The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of Vendor's decision	Credentialing of all service providers applying for network provider status shall be completed as follows: All files - 100% within 90 days.	Monthly
Adverse Action Notification	Report of any action that denies, restricts, encumbers, revokes, or suspends a Practitioner's professional license, medical staff privileges, Vendor Provider status and or eligibility in the Medicare program	Within three (3) business days of Vendor taking action or receiving notification	Within three (3) business days of Vendor taking action or receiving notification
Sanctions, Terminations or Suspensions	Report deficiencies that result in suspension or termination to appropriate authorities such as the National Practitioner Data Bank, CMS and United	Within three (3) business days of action	Within three (3) business days of action
Provider Disclosure of Ownership	Providers must execute new disclosures on a credentialing cycle of every 3 years.	Vendor will collect, track and review all disclosures	N/A

SECTION 7
COVERED PERSON SETUP AND MAINTENANCE SERVICES

March shall comply with the performance metrics and reporting requirements related to Covered Person setup and maintenance services as set forth in the table below. Monthly reporting shall be provided by the tenth (10^{th}) day of the following month. Quarterly reporting shall be provided within twenty (20) calendar days after the end of each quarter.

Metric	Metric Description	Measurement	Expected Value	Frequency
Download of Eligibility File Turnaround Time	Number of days for an eligibility file to be loaded into and available in the system for use by Member Services and Claims	# of days between receipt of the eligibility files and downloading of files into the system.	2 business days 95% of the time	Monthly
Eligibility Edit Reporting	Summary list of new records, identified as additions, deletions and % change.		March will notify the health plan if there is a greater than 5% change in the entire file	Ad Hoc

SECTION 8
PROVIDER SUPPORT SERVICES

March shall comply with the performance metrics and reporting requirements related to provider and member support services as set forth in the table below. These metrics will be reported with respect to United. Monthly reporting shall be provided by the tenth (10^{th}) day of the following month.

Metric	Metric Description	Measurement	Expected Value	Frequency
Provider Customer Service – Call Volume	Total number of inquiries answered by a representative	# of calls received	As reported	Monthly, Annual Trending

Provider Customer Service – Answering Speed	Average time in seconds between the time a caller is connected and a representative answers the call for services	Average # of seconds	30 Seconds	Monthly, Annual Trending
Provider Customer Service – Service Level	% of calls answered within X seconds	% of calls	90% of provider calls will have an average speed to answer of 30 seconds	Monthly, Annual Trending
Provider Customer Service – Average Hold Time	Average time that a caller is not connected with a representative, for the duration of the call	Average time in seconds	100% of all calls, whether incoming or outgoing, will be placed on hold for no more than an average of 180 seconds	Monthly, Annual Trending
Provider Customer Service – Abandonment Rate	Number of calls that are abandoned before reaching a representative or disconnected after reaching a representative in current month The percentage of total calls received that are abandoned (abandoned calls divided by total calls received in current month)	# abandoned % of total calls received that are abandoned	Abandonment Rate of less than 5%	Monthly, Annual Trending

SECTION 9
COVERED PERSON APPEALS

March shall comply with the performance metrics and reporting requirements related to Covered Person appeals as set forth in the table below. Monthly reporting shall be provided by the tenth (10^{th}) day of the following month.

Metric	Metric Description	Measurement	Expected Value	Frequency
YTD Appeals Assistance Requested from Plan	Number of member appeals that Plan requested assistance from March	# of YTD appeals received	As Reported	Monthly, Annual Trending

SECTION 10
QUALITY ASSURANCE

March shall comply with the performance metrics and reporting requirements related to quality assurance as set forth in the table below.

Metric	Metric Description	Measurement	Expected Value	Frequency
Provider Satisfaction Survey	Annual Survey of Provider Satisfaction with March	Survey results provided	Providers overall are generally satisfied	Annual report due April 15^{th}

SECTION 11
COMPLIANCE

March shall comply with the performance metrics and reporting requirements related to compliance as set forth in the table below.

Metric	Metric Description	Measurement	Expected Value	Frequency
Report of Compliance Incidents/FWA	Vendor must report (with supporting documentation) to United within 24 hours of any evidence of member or provider fraud and abuse related to United Vendor will provide a summary report of all compliance incidents or incidents of suspected fraud, waste and/or abuse as investigated by Vendor and relating to United	Report the date of the report, Member name, ID number, date of alleged fraud/abuse, description of alleged fraud/abuse, referrals made, Provider name, address and NPI# or Medicaid ID# if applicable Report provided along with relevant details	As Reported	Submit to plan immediately upon identification. Quarterly summary by the 20th of the month following the end of Quarter.
Sanction/Exclusion Screening Notification	Vendor will conduct periodic monitoring of governmental exclusion lists & databases and report any findings that result. Vendor must immediately report any person/provider who has been excluded	Report the date match was found, name of person/provider, which exclusion lists/sites match was found, action taken	As Reported	Vendor to submit to plan immediately upon identification.

SECTION 12
UTILIZATION

March shall comply with the performance metrics and reporting requirements related to benefit utilization as set forth in the table below. Monthly reporting shall be provided by the tenth (10^{th}) day of the following month.

Metric	Metric Description	Measurement	Expected Value	Frequency
Utilization Summary	Report of utilization of services, including: Total % utilization of benefit, Total # materials	% utilization # materials	As Reported	Semi-Annual by January 15^{th} and July 15th

EXHIBIT C
DELEGATION OF CREDENTIALING ADDENDUM

THIS DELEGATED CREDENTIALING ADDENDUM (this "Addendum"), supplements and is made a part of the Administrative Services Agreement (the "Agreement") between **MARCH VISION CARE GROUP, INCORPORATED** ("Vendor") and **UNITEDHEALTHCARE OF LOUISIANA, INC.** ("United").

SECTION 1
DEFINITIONS

All capitalized terms not otherwise defined herein shall have the meanings given to such terms in the Agreement.

1.1 **Complaint:** Any written or oral communication made by a Covered Person or his or her authorized representative that expresses dissatisfaction about United, a Participating Practitioner or Component, or United's products, benefits, coverage, services or operations.

1.2 **Component:** A hospital, skilled nursing facility, outpatient surgical center, free-standing surgical center, such as stand-alone abortion clinics and multispecialty outpatient surgical centers, or a similar facility, or as defined by the Credentialing Authorities, that is required by United and the Credentialing Authorities to be Credentialed in order to participate in the United Network. For purposes of this Agreement, Component specifically excludes all home health care agencies and behavioral health facilities providing mental health or substance abuse services.

1.3 **Credential, Credentialing or Recredentialing:** The process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Practitioners or Components, as set forth the Credentialing Plan and pursuant to Credentialing Authorities.

1.4 **Credentialing Authorities:** The National Committee for Quality Assurance ("NCQA"), the Center for Medicare and Medicaid Services ("CMS"), as applicable, and other State and federal regulatory authorities; to the extent such authorities dictate credentialing addendum requirements.

1.5 **Credentialing Plan:** United's policy for Credentialing and Recredentialing of Practitioners and Components. To the extent the Credentialing Plan varies from any legal requirement, the law will control. The Credentialing Plan shall also include any State or federal regulatory requirements attached to the Credentialing Plan.

1.6 **Participating Component:** A Component that is included in the United Network, directly or through another entity, pursuant to a Participation Agreement.

1.7 **Participating Practitioner:** A Practitioner that is included in the United Network, directly or through another entity, pursuant to a Participation Agreement.

1.8 **Participation Agreement:** An agreement that sets forth the terms and conditions under which a Practitioner or a Component, either directly or through another entity, participates in Vendor's Network.

1.9 **Practitioner:** A licensed or otherwise appropriately qualified health care professional or entity who is qualified and, when applicable, duly licensed and/or certified by the state in which he, she or it is located to furnish Covered Services when acting within the scope of his, her or its license or certification.

1.10 **Quality of Care:** The degree to which health services for Covered Persons and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include the following: Covered Person perspective issues, safety of the health care environment, accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of care.

1.11 **United Network:** The network of Practitioners and/or Components established by United to provide or arrange for the provision of health care services to Covered Persons.

1.12 **Vendor Network:** The network of Practitioners and/or Components established by Vendor to provide or arrange for the provision of health care services.

SECTION 2
VENDOR RESPONSIBILITIES

2.1 **Policies and Procedures.** Vendor may utilize its own policies and procedures for the performance of delegated activities set forth in this Addendum, subject to the terms and provisions hereof, and provided that such policies and procedures remain in compliance with the reasonable requirements of United, and applicable federal and State law and accreditation standards. All such policies and procedures shall be forwarded to United, on an annual basis or upon request, for ongoing review and approval.

2.2 **Compliance with Standards and Applicable Law.** Vendor shall at all times meet the applicable standards for Credentialing and Recredentialing, as required by Credentialing Authorities and as set forth in the most current Credentialing Plan. United shall provide Vendor a copy of the Credentialing Plan through regular mail or electronically. United may unilaterally change its Credentialing Plan by providing thirty (30) days prior written notice to Vendor of the changes and their effective dates; provided, however, if required by Credentialing Authorities, United may unilaterally change the Credentialing Plan immediately without prior written notice to Vendor of the changes and their effective dates. Any notice provided to Vendor under this Section may be in electronic format. Vendor shall also comply with all applicable laws related to the performance of delegated activities.

2.3 **Delegated Activities.** Vendor shall perform such delegated activities as United deems appropriate, including the Credentialing of Practitioners and Components in accordance with the Credentialing Plan, as may be amended from time to time, and the requirements set forth by the Credentialing Authorities. Vendor understands and agrees that Practitioners and Components may not provide health care services to a Covered Person unless and until such Practitioners and Components are properly Credentialed and have executed or are otherwise subject to a Participation Agreement. Vendor will not communicate anything to the contrary to a Practitioner or Component.

2.4 **Credentialing of Practitioners.** When required, the Credentialing of Practitioners by Vendor shall include, but is not limited to:

(a) establishing and maintaining credentialing standards, policies and procedures;

(b) receiving the provider's application, reapplication and attestation, including documentation required under State and federal rules, regulations and any applicable contract between United and the State for the provision of Covered Services to Covered Persons;

(c) conducting office site visits as defined by Vendor's policy or as required by applicable law or State program and medical record keeping assessments and requiring a passing score, as defined by Vendor's policy;

(d) confirming the Practitioner has not been denied Credentialing from United in the previous twenty-four (24) months;

(e) confirming the Practitioner has active hospital staff privileges at a participating hospital, if applicable to Practitioner's practice;

(f) confirming the Practitioner is Medicaid-enrolled and agrees to comply with all pertinent Medicaid regulations as applicable for participation in Medicaid programs;

(g) making decisions on Credentialing;

(h) the ongoing monitoring and evaluation of Complaints, sanctions on licenses, Medicare/Medicaid Complaints, and Quality of Care issues;

(i) primary source verification, where applicable, of the Practitioner's education, including successful completion of a residency program, board certifications, current licensure or certification and any sanctions or limitations thereon;

(j) registration with the Drug Enforcement Agency;

(k) possession of a State Controlled Dangerous Substance Certificate;

(l) current, active malpractice insurance or State-approved alternative;

(m) malpractice history;

(n) work history;

(o) verification that the Practitioner is not ineligible, excluded or debarred and does not have any restrictions, sanctions, censures or other disciplinary action (other than action regarding incomplete medical records) against him/her by any state or county medical association, medical staff, hospital, state or federal programs, including but not limited to, Medicare or Medicaid; and

(p) recredentialing must be completed at least every three (3) years, unless otherwise required by applicable law or State agency.

2.5 **Credentialing of Components.** Vendor shall Credential the Components that apply for participation in the United Network. When required, the Credentialing of Components shall include, but is not limited to:

(a) establishing and maintaining Credentialing standards, policies and procedures;

(b) verification of current licensure or certification and any sanctions or limitations thereon;

(c) verification that the Component is not ineligible, excluded or debarred and does not have any restrictions, sanctions or other disciplinary action against it by any state or federal programs;

(d) verification of current, active malpractice insurance or State-approved alternative;

(e) appropriate accreditation, certification or satisfactory alternative or a passing score on Component site visits;

(f) making decisions on Credentialing; and

(g) the ongoing monitoring and evaluation of Complaints, sanctions on licenses, Medicare/Medicaid Complaints, and Quality of Care issues.

2.6 **Right of Appeal.** If Vendor makes a decision to suspend or terminate a Participating Practitioner or Participating Component from Vendor's network, Vendor shall, when required by State or federal law, offer such Participating Practitioner or Component the right to appeal or request a fair hearing. Vendor shall conduct the appeals process and report the action, as required by the Credentialing Authorities.

2.7 **Audit Participation.** Vendor shall fully cooperate and participate, either telephonically or personally, in audits conducted by Credentialing Authorities, including interview sessions, upon fourteen (14) calendar days notice from United, unless the Credentialing Authorities require

a shorter timeframe. This Section shall survive any termination of the Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.8 **Records.** Unless applicable statutes or regulations require a longer time period, Vendor shall retain all information and records related to this Addendum according to United's record retention policies, or for at least ten (10) years, or as otherwise required by law. United, Credentialing Authorities and any federal, State or local governmental official or their authorized representatives who audit United shall have access to all records or copies which are pertinent to and involve transactions related to this Addendum if such access is necessary to comply with United's policies, applicable accreditation standards, statutes, or regulations. Photocopying and mailing of records pursuant to this section shall be at no charge to United. United and Vendor shall maintain the privacy of all information regarding Covered Persons, Covered Services Participating Practitioners and Participating Components in accordance with applicable statutes and regulations. This Section shall survive any termination of the Agreement or the revocation of delegated activities pursuant to Section 3.3 of this Addendum.

2.9 **Improvement Action Plan.** In the event that, during an audit or any other time during the term of this Addendum, United discovers any deficiency(ies) in Vendor's delegated activities, Vendor shall develop an Improvement Action Plan for the specific activity that United determines to be deficient. The Improvement Action Plan shall include specifics of and timelines for correcting any deficiencies or issues contained in the audit report to Vendor. Vendor shall implement the Improvement Action Plan within the specified timeframes. In the event the Improvement Action Plan is not developed and/or implemented within such timeframes, United may revoke all or certain delegated activities pursuant to Section 3.3 of this Addendum. If deficiencies are identified, United retains the right to increase its monitoring, evaluations, and audits of Vendor until the deficiencies are corrected.

2.10 **Documentation and Information.** Vendor shall provide to United the following documentation and information according to the time periods listed below:

(a) Inquiries and Investigations. Within five (5) business days of Vendor's knowledge of actions taken as a result of any inquires or investigation by regulatory agencies, or Quality of Care issues investigated by Vendor, that result in the limitation, restriction, suspension or termination of a Participating Practitioner's or Component's ability to provide services to Covered Persons, Vendor shall provide United with documentation related to such inquires or investigations. Vendor is not required to provide United with information that is peer review protected or documents and deliberation considered confidential or privileged by HCQIA (Health Care Quality Improvement Act-1986) or according to state peer review laws.

(b) United Network Updates. Vendor shall provide United with information about Participating Practitioners or Components who have changes to their demographic information, who have been Credentialed or Recredentialed, or who have been terminated, suspended, or restricted from participating in Vendor's network as changes occur, but no later than five (5) business days from the time such changes occur. Such

information shall be in an electronic format mutually agreed upon by the parties and shall include all information United needs to meet its database requirements. A sample of the format, content and where to submit this information shall be made available to Vendor on an electronic basis. United may unilaterally change its Credentialing and Recredentialing database requirements by providing thirty (30) days advance notice, in an electronic format, to Vendor of the changes and their effective date.

(c) Improvement Action Plan Items. Every six months after the Effective Date of the Agreement, Vendor shall provide United with any outstanding Improvement Action Plan items, if applicable.

(d) List of Participating Practitioners and Components. Upon United's request, which will be at least semi-annually and annually, Vendor shall provide United with a complete list of Participating Practitioners and Components currently active in the United Network and Credentialed by Vendor.

SECTION 3
UNITED'S RESPONSIBILITIES

3.1 **Pre-Delegation Assessment.** The parties acknowledge that United has completed a pre-assessment audit of Vendor to assess its ability to fulfill the terms of this Addendum.

3.2 **United Oversight, Monitoring and Audit.** United shall perform oversight and monitoring of Vendor's performance under this Addendum, including but not limited to, review of the documentation and information related to delegated activities, as set forth in Section 2.10 of this Addendum. At any time, but at least annually, United will audit records and documents related to the activities performed under this Addendum, including but not limited to Vendor's Credentialing and Recredentialing files. United, in its sole discretion, will conduct desk-top review of Vendor's written policies and procedures and will perform file review audits at the site of Vendor. United will provide written notice of annual audits at least thirty (30) calendar days prior to the audit. United shall provide a report of its audit findings to Vendor within thirty (30) calendar days of the audit's conclusion. For all additional audits, United shall provide at least fourteen (14) calendar days prior written notice, unless State or federal regulators or other Credentialing Authorities require a shorter timeframe. The audit notes shall include a list of the records to be reviewed.

3.3 **Revocation of Delegation.** United may revoke the delegation of some or all of the activities which Vendor is obligated to perform under this Addendum in the event Vendor fails to meet the requirements of United, applicable law, regulations, or accreditation standards in the performance of the delegated activity(ies).

3.4 **Right to Approve, Suspend, or Terminate Practitioners.** United retains the absolute right to approve or reject a Practitioner or Component for participation in the United Network or in any or all of its Benefit Plans. United also has the right to conduct independently any additional processes or verification procedures it deems necessary or appropriate, until such

Practitioner or Component is Credentialed. United shall promptly inform Vendor and the affected Practitioner or Component of any denial, restriction or revocation of the provider's participation status in the United Network or a Benefit Plan, as determined by United. United also retains the absolute right to terminate or suspend any Participating Practitioners or Components from participation in the United Network or in any or all of its Benefit Plans. In no case shall this Section be construed to obligate Vendor to contract with or make use of any particular health care facility or professional.

SECTION 4
TERM

4.1 **Term.** This Addendum shall run co-terminously with the Agreement, except that United may revoke any or all delegated activities at any time pursuant to Section 3.3.

4.2 **Records Upon Termination.** Upon the effective date of termination of the Agreement or revocation of all Delegated Activities pursuant to Section 3.3, Vendor shall provide United with a list of all Participating Practitioners and Participating Components that Vendor has Credentialed on United's behalf. Also, upon request by United, and if agreed to by Vendor, Vendor shall provide United with copies of Vendor's Credentialing and Recredentialing files that pertain to this Addendum. Such files shall be provided to United no more than thirty (30) days after the effective date of termination of the Agreement or revocation of all Delegated Activities pursuant to Section 3.3 of this Addendum.

SECTION 5
SUB-DELEGATION

Under certain circumstances, United may allow Vendor to sub-delegate all or a part of its delegated activities under this Addendum to another entity. Prior to any such sub-delegation arrangement, Vendor must:

(a) Warrant that the sub-delegation agreement between Vendor and the sub-delegated organization meets the requirements of Credentialing Authorities and all terms and provisions of this Addendum;

(b) Agree to oversee and perform audits of those activities it has sub-delegated to another entity in accordance with the requirements of Credentialing Authorities and this Addendum;

(c) Provide all reports to United that are required under this Addendum;

(d) Not enter into the sub-delegation agreement until it receives United's prior written approval; and

(e) Assure that vendor's ownership interest in the sub-delegate is less than 100%.

EXHIBIT D
LOUISIANA MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX

SEE ATTACHED

LOUISIANA MEDICAID AND CHIP PROGRAM
REGULATORY REQUIREMENTS APPENDIX
MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the Subcontract between UnitedHealthcare Insurance Company, contracting on behalf of itself or one of its Affiliates (collectively, "United") and Subcontractor.

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the State of Louisiana's Bayou Health and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company. UnitedHealthcare of Louisiana, Inc. is an Affiliate.

2.2 **Covered Person:** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or DHH:** The Louisiana Department of Health and Hospitals.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract(s) with DHH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Bayou Health and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Covered Services; Definitions Related to Coverage. Provider shall follow the State Contract's requirements for the provision of Covered Services. A description of the package of benefits offered by DHH under the State Program is available on the DHH website at http://www.makingmedicaidbetter.com/. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be based on the individual's medical needs and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR Part 438.114(a) and § 1932(b)(2) of the Social Security Act of 1935 (42 U.S.C. §

1396u-2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition. Emergency Services also include services defined as such under Section 1867(e) of the Social Security Act ("anti-dumping provisions"). There are no prior authorization requirements for Emergency Services.

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial or non-Medicaid/CHIP members or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and

obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. Subcontractor and Provider shall accept the final payment made by United as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the Covered Persons(s). Covered Person shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. At all times during the Agreement, Subcontractor shall, and shall ensure Provider indemnifies, defends, protects, and holds harmless DHH and any of its officers, agents, and employees from:

(a) Any claims, losses, or suits relating to activities undertaken by Subcontractor and/or Provider pursuant to the Agreement or pursuant to the State Contract;

(b) Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for Subcontractor and/or Provider in connection with performance of the Agreement or in connection with performance of the State Contract;

(c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Provider and/or Subcontractor, its agents, officers, employees, or contractors in performance of the Agreement or in performance of the State Contract;

(d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor and/or Provider, its agents, officers, employees, or contractors, by Subcontractor's and/or Provider's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the State Contract, or by federal or State regulations or statutes;

(e) Any failure of Subcontractor and/or Provider, its agents, officers, employees, or contractors, to observe federal or State laws, including but not limited to labor laws and minimum wage laws;

(f) Any claims for damages, losses, or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

(g) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor and/or Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of United, Subcontractor, Provider, or DHH (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), United, Subcontractor, Provider, or DHH will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the State Contract remains in full force and effect, United shall be liable for authorizing services required in accordance with the State Contract.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records,

to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, DHH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Retention. Subcontractor shall, and shall require Provider to retain all administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by DHH (whether paper or electronic) for the later of: (i) six (6) years from the expiration date of the State Contract, including any extension(s) thereof; or (ii) for Covered Person records, for six (6) years after the last payment was made for services provided to the Covered Person (an exception to this requirement includes records pertaining to once in a lifetime events, including but not limited to appendectomy and amputations, etc., which must be retained indefinitely and may not be destroyed); or (iii) such other period as required by law. Notwithstanding the foregoing, if the records are under review or audit or related to any matter in litigation, such records shall be retained until completion of the audit, review or litigation and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

The above record retention requirements pertain to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least six (6) years, commencing from the last date of treatment.

(d) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to DHH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Inspection, Audit and Evaluation

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that DHH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the

quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as often as they may deem necessary during the State Contract period and for a period of six (6) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

(b) By DHH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require that Provider understand that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not

identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Subcontractor shall, and shall require Provider to notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract and DHH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract and DHH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and DHH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the DHH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's and/or Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.11 Excluded Individuals. By signing the Agreement, Subcontractor certifies, and shall require Provider to certify to the best of Subcontractor's and Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under either § 1128 or § 1128A of the Social Security Act;

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion

information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. United will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

4.12 Cultural Competency. Subcontractor shall, and shall require Provider to deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Subcontractor shall, and shall require Provider to take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Agreement must be submitted to United to submit to the Department for prior approval. In addition, Subcontractor shall, and shall require Provider to comply with the State Contract's requirements related to marketing communications.

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist DHH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network, employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA)
Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies,

detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Outstanding Claim Information. In the event of termination of the Agreement, Subcontractor shall, and shall require Provider to promptly supply to United or its designee all information necessary for the reimbursement of any outstanding Medicaid claims.

4.16 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.17 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in DHH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information.

4.18 Quality Assessment/Utilization Management Review. Subcontractor shall, and shall require Provider to adhere to the State Program's Quality Assessment and Performance Improvement (QAPI) program requirements, as outlined in the State Contract and the Quality Companion Guide, which are incorporated herein by reference and shall be furnished to Subcontractor and/or Provider upon request. Subcontractor shall, and shall require Provider to cooperate with United's QAPI and utilization management (UM) programs, which adhere to all DHH QAPI and UM program requirements. Subcontractor agrees, and shall require Provider to agree to participate and cooperate in any internal or external quality assessment review, utilization management, or grievance procedures established by United and/or the Department or its designee, whether such review or procedures are announced or unannounced.

4.19 Insurance. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. DHH and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider.

4.20 Licensing Requirements. Subcontractor represents, and shall require that Provider represent that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate Louisiana licensing body or standard-setting agency, as

applicable. Subcontractor represents, and shall require that Provider represent that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Subcontractor represents, and shall require Provider to represent that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the Office of the Louisiana Attorney General. Subcontractor shall, and shall require Provider to maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Subcontractor and Provider by United under the Agreement. If at any time during the term of the Agreement, Subcontractor and/or Provider are not properly licensed as described in this Section, Subcontractor shall, and shall require Provider to discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

4.21 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.22 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United.

4.23 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.24 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.25 Data and Reports. Subcontractor shall, and shall ensure Provider submits to United all reports and clinical information which United or DHH may require for reporting purposes pursuant to the State Contract, including but not limited to encounter data, HEDIS, AHRQ and EPSDT data and reports, where applicable. Provider shall utilize DHH's Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations. As applicable, if United has entered into alternative reimbursement arrangements with Subcontractor and/or Provider (with prior approval

by the Department), Subcontractor and Provider are required to submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by United. NOTE: United is not allowed to enter into alternative reimbursement arrangements with FQHCs or RHCs.

4.26 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or DHH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 180 days from the date of service.

4.27 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.28 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by DHH.

4.29 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the scope of Subcontractor's and/or Provider's practice.

4.30 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.31 Appeals and Grievances. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with DHH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have correct and adequate supply of such public notices.

4.32 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that DHH has the right to direct United to impose financial

consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

4.33 Primary Care Provider ("PCP") Linkages. If Provider is a PCP, Subcontractor shall require Provider to stipulate by signing an agreement that Provider's total number of Medicaid/CHIP members for the State Program will not exceed 2,500 lives per full-time physician or 1,000 lives per mid-level practitioner or physician extender up to a cap of 2,500 lives. Prior to executing an Agreement, Subcontractor, Provider and United shall specify the number of linkages United may link to Provider.

4.34 Birth Registration. As applicable, Subcontractor shall ensure Provider registers all births through LEERS (Louisiana Electronic Event Registration System) administered by the DHH/Vital Records Registry. Hospital Providers must notify United and DHH of the birth of a newborn when the mother is a member of United, complete the web-based DHH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to DHH.

4.35 Laboratory Services. If Provider performs laboratory services, Subcontractor shall ensure Provider meets all applicable State and federal requirements, including but not limited to 42 CFR Sections 493.1 and 493.3, as may be amended from time to time. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Subcontractor shall require that Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Subcontractor shall further ensure Provider provides a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

4.36 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall ensure Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Agreement. Subcontractor understands, and shall ensure Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.37 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

4.38 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

4.39 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

4.40 Advance Directives. Subcontractor shall, and shall ensure Provider complies with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

4.41 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

3.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and applicants.

3.43 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

SECTION 5
UNITED REQUIREMENTS

5.1 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract

if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6
OTHER REQUIREMENTS

6.1 State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any requirement or provision of the Agreement or this Appendix is determined by DHH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Agreement and this Appendix shall remain in full force and effect.

6.2 Ongoing Monitoring. As required under the State Contract, United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Agreement and shall perform periodic formal reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or DHH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established by DHH in the State Contract and DHH-issued guides.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of DHH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and DHH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that DHH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the State Contract. United will submit and obtain prior approval from DHH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of DHH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 Health Care-Acquired/Preventable Conditions. United and Subcontractor acknowledge and agree that United is prohibited from making payments to Subcontractor for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by DHH.

6.10 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.11 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor

acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by DHH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

6.12 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.13 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.16 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

EXHIBIT E

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Addendum") is incorporated into and made part of Administartive Services Agreement ("Agreement") by and between March Vision Care Group, Incorporated ("Business Associate") and UnitedHealthcare of Louisiana, Inc. on behalf of itself and its Affiliates ("Covered Entity") (each a "Party" and collectively the "Parties").

This Addendum also is intended to comply with applicable obligations under Title V of the Gramm-Leach-Bliley Act (15 U.S.C. sec. 6801 et seq.) and insurance commissioner regulations implementing Title V ("GLBA") that are applicable to Covered Entity's relationship with "nonaffiliated third party service providers" to ensure the integrity and confidentiality of nonpublic personal information that Business Associate may create or receive for or from Covered Entity ("NPI").

The Parties hereby agree as follows:

1. DEFINITIONS

1.1 Unless otherwise specified in this Addendum, all capitalized terms used in this Addendum not otherwise defined have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended and supplemented by HITECH, as each is amended from time to time (collectively, "HIPAA").

1.2 "Affiliate" for purposes of this Addendum, means any entity that is a subsidiary of UnitedHealth Group.

1.3 "Breach" means the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exclusions set forth, in 45 C.F.R. § 164.402.

1.4 "Breach Rule" means the federal breach regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Part 164 (Subpart D).

1.5 "Compliance Date" means the later of September 23, 2013 or the effective date of the Agreement.

1.6 "Electronic Protected Health Information" or "ePHI" means PHI that is transmitted or maintained in Electronic Media.

1.7 "HITECH" means Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and

Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, and all associated existing and future implementing regulations, when and as each is effective.

1.8 "PHI" means Protected Health Information, as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received, maintained, created or transmitted on behalf of, Covered Entity by Business Associate in performance of the Services.

1.9 "Privacy Rule" means the federal privacy regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

1.10 "Security Rule" means the federal security regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Parts 160 and 164 (Subparts A & C).

1.11 "Services" means, to the extent and only to the extent they involve the receipt, creation, maintenance, transmission, use or disclosure of PHI, the services provided by Business Associate to Covered Entity as set forth in the Agreement, as amended by written agreement of the Parties from time to time.

2. RESPONSIBILITIES OF BUSINESS ASSOCIATE

With regard to its use and/or disclosure of PHI, Business Associate agrees to:

2.1 not use and/or further disclose PHI except as necessary to provide the Services, as permitted or required by this Addendum, and in compliance with each applicable requirement of 45 C.F.R. § 164.504(e), or as otherwise Required by Law; provided that, to the extent Business Associate is to carry out Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of those obligations.

2.2 implement and use appropriate administrative, physical and technical safeguards and, as of the Compliance Date, comply with applicable Security Rule requirements with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by this Addendum, including at a minimum, but in any event not limited to, any safeguards set forth in the Agreement or other applicable contracts or agreements between the Parties. For the avoidance of doubt, the requirements set forth in the Agreement or other applicable contracts or agreements between the Parties do not limit in any way whatsoever Business Associate's obligations under this Section 2.2 to comply with applicable Security Rule requirements.

2.3 without unreasonable delay, and in any event on or before 48 hours after its discovery by Business Associate, report to Covered Entity in writing: (i) any use or disclosure of PHI not provided for by this Addendum of which it becomes aware in accordance with 45 C.F.R. § 164.504(e)(2)(ii)(C); and/or (ii) any

Security Incident of which Business Associate becomes aware in accordance with 45 C.F.R. § 164.314(a)(2)(i)(C).

2.4 without unreasonable delay, and in any event on or before 48 hours after its Discovery by Business Associate, notify Covered Entity of any incident that involves an unauthorized acquisition, access, use or disclosure of PHI, even if Business Associate believes the incident will not rise to the level of a Breach. The notification shall include, to the extent possible, and shall be supplemented on an ongoing basis with: (i) the identification of all individuals whose Unsecured PHI was or is believed to have been involved; (ii) all other information required for or requested by Covered Entity to perform a risk assessment in accordance with 45 C.F.R. § 164.402 with respect to the incident to determine whether a Breach of Unsecured PHI occurred; and (iii) all other information reasonably necessary to provide notice to individuals, HHS and/or the media, all in accordance with the Breach Rule. Notwithstanding the foregoing, in Covered Entity's sole discretion and in accordance with its directions, and without limiting in any way any other remedy available to Covered Entity at law, equity or contract, including but not limited to any rights or remedies the Covered Entity may have under the Agreement, Business Associate (i) shall conduct, or pay the costs of conducting, an investigation of any incident required to be reported under this Section 2.4, (ii) shall reimburse and pay Covered Entity for all expenses and costs incurred by Covered Entity that arise from an investigation of any incident required to be reported under this Section 2.4 and (iii) shall provide, and/or pay the costs of providing, the required notices as set forth in this Section 2.4.

2.5 in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and 45 C.F.R. § 164.308(b)(2), ensure that any subcontractors of Business Associate that create, receive, maintain or transmit PHI on behalf of Business Associate agree, in writing, to the same restrictions and conditions on the use and/or disclosure of PHI that apply to Business Associate with respect to that PHI, including complying with the applicable Security Rule requirements with respect to ePHI; provided that, in any event Business Associate shall require its subcontractors (and shall require those subcontractors to require their subcontractors) to report to Business Associate any use or disclosure of PHI or Security Incident required to be reported under Sections 2.3 and 2.4 on or before forty-eight (48) hours after its discovery by any of those subcontractors.

2.6 make available its internal practices, books and records relating to the use and disclosure of PHI to the Secretary for purposes of determining Covered Entity's compliance with the Privacy Rule.

2.7 document, and within thirty (30) days after receiving a written request from Covered Entity, make available to Covered Entity information necessary for Covered Entity to make an accounting of disclosures of PHI about an Individual or, when and as requested by Covered Entity, make that information available directly to an Individual, all in accordance with 45 C.F.R. § 164.528 and, as of the

later of the date compliance is required by final regulations or the effective date of the Agreement, 42 U.S.C. § 17935(c).

2.8 provide access to Covered Entity, within fifteen (15) days after receiving a written request from Covered Entity, to PHI in a Designated Record Set about an Individual, or when and as requested by Covered Entity, provide that access directly to an Individual, all in accordance with the requirements of 45 C.F.R. § 164.524, including as of the Compliance Date, providing or sending a copy to a designated third party and providing or sending a copy in electronic format in accordance with 45 C.F.R. § 164.524.

2.9 to the extent that the PHI in Business Associate's possession constitutes a Designated Record Set, make available, within thirty (30) days after a written request by Covered Entity, PHI for amendment and incorporate any amendments to the PHI as requested by Covered Entity, all in accordance with 45 C.F.R. § 164.526.

2.10 accommodate reasonable requests for confidential communications in accordance with 45 C.F.R. § 164.522(b), as requested by Covered Entity.

2.11 take all necessary steps, at the request of Covered Entity, to comply with requests by Individuals not to send PHI to a Health Plan in accordance with 45 CFR § 164.522(a) as of the Compliance Date.

2.12 notify Covered Entity in writing within three (3) days after its receipt directly from an Individual of any request for an accounting of disclosures, access to or amendment of PHI or for confidential communications as contemplated in Sections 2.7-2.10.

2.13 request, use and/or disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure; provided, that Business Associate shall comply with 45 C.F.R. §§ 164.502(b) and 164.514(d) as of the Compliance Date.

2.14 not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 45 C.F.R. § 164.502(a)(5)(ii) as of the Compliance Date.

2.15 not make or cause to be made any communication about a product or service that is prohibited by 45 C.F.R. §§ 164.501 and 164.508(a)(3) as of the Compliance Date.

2.16 not make or cause to be made any written fundraising communication that is prohibited by 45 C.F.R. § 164.514(f) as of the Compliance Date.

2.17 mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate that is not permitted by the requirements of this Addendum.

2.18 comply with all applicable federal, state and local laws and regulations.

2.19 not use, transfer, transmit or otherwise send or make available, any PHI outside of the geographic confines of the United States of America without Covered Entity's advance written consent.

2.20 Government Program Requirements. To the extent that Business Associate receives, uses or discloses PHI pertaining to Individuals enrolled in managed care plans through which Covered Entity or one or more of its affiliates participate in government funded health care programs, receipt, use and disclosure of the PHI pertaining to those individuals shall comply with the applicable program requirements.

2.21 Privacy and Safeguards for Financial Data. Business Associate understands and acknowledges that to the extent it is a nonaffiliated third party service provider under the GLBA and that, in the performance of the Services, Business Associate creates or receives NPI, Business Associate (i) shall not use or disclose NPI for any purpose other than to perform the Services, (ii) shall implement proper administrative, technical and physical safeguards designed to ensure the security and confidentiality of the NPI, protect against any anticipated threats or hazards to the security or integrity of the NPI and protect against unauthorized access to or use of the NPI that could result in substantial harm or inconvenience to any Individual, and (iii) shall, for as long as Business Associate has NPI, provide and maintain proper safeguards for the NPI in compliance with this Addendum and the GLBA.

3. OTHER PERMITTED USES AND DISCLOSURES OF PHI

Unless otherwise limited in this Addendum, in addition to any other uses and/or disclosures permitted or required by this Addendum, Business Associate may:

3.1 use and disclose PHI, if necessary, for proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that the disclosures are Required by Law or any third party to which Business Associate discloses PHI for those purposes provides written assurances in advance that: (i) the information will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to the third party or as Required by Law; and (ii) the third party promptly will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached.

4. TERMINATION AND COOPERATION

4.1 Termination. If Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of this Addendum then Covered Entity may provide written notice of the breach or

violation to Business Associate and Business Associate must cure the breach or end the violation on or before thirty (30) days after receipt of the written notice. In the absence of a cure reasonably satisfactory to Covered Entity within the specified timeframe, or in the event the breach is reasonably incapable of cure, then Covered Entity may terminate the Agreement and/or this Addendum.

4.2 Effect of Termination or Expiration. Within thirty (30) days after the expiration or termination for any reason of the Agreement and/or this Addendum, Business Associate shall return or destroy all PHI, if feasible to do so, including all PHI in possession of Business Associate's subcontractors. To the extent return or destruction of the PHI is not feasible, Business Associate shall notify Covered Entity in writing of the reasons return or destruction is not feasible and, if Covered Entity agrees, may retain the PHI subject to this Section 4.2. Under any circumstances, Business Associate shall extend any and all protections, limitations and restrictions contained in this Addendum to Business Associate's use and/or disclosure of any PHI retained after the expiration or termination of the Agreement and/or this Addendum, and shall limit any further uses and/or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

4.3 Cooperation. Each Party shall cooperate in good faith in all respects with the other Party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action or other inquiry.

5. MISCELLANEOUS

5.1 Construction of Terms. The terms of this Addendum to the extent they are unclear, shall be construed to allow for compliance by Covered Entity with HIPAA.

5.2 Survival. Sections 4.2, 4.3, 5.1, 5.2, and 5.3 shall survive the expiration or termination for any reason of the Agreement and/or of this Addendum.

5.3 No Third Party Beneficiaries. Nothing in this Addendum shall confer upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

5.4 Independent Contractor. Business Associate and Covered Entity are and shall remain independent contractors throughout the term. Nothing in this Addendum or otherwise in the Agreement shall be construed to constitute Business Associate and Covered Entity as partners, joint venturers, agents or anything other than independent contractors.

EXHIBIT F

SECURITY

THIS SECURITY EXHIBIT (this "Exhibit") applies when March Vision Care Group, Incorporated ("Vendor") requires electronic access to UnitedHealthcare of LA, Inc. and/or United HealthCare Services, Inc. (collectively, "United") Information (as defined in Section 1 below) and/or United Information Systems (as defined in Section 1 below). This Exhibit applies in addition to any of Vendor's obligations under the Administrative Services Agreement between the parties (the "Agreement"), any Business Associate Agreement or other agreement, or any requirements imposed upon Vendor by applicable laws or regulations, and in addition to any United due diligence that may be performed regarding Vendor's systems and security practices. In the event of a conflict between this Exhibit and any other term between the parties, the terms most protective of United shall apply.

SECTION 1
DEFINITIONS

The following terms shall have the meanings as set forth below:

1.1 **"Security Incident"** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of United Information or interference with the operations of any of the Vendor Processing Resources. Security Incidents are classified as follows:

(a) **"High Severity"** or severity 1 (severe impact) means external loss or exposure of United Information, causing significant impact to mission critical information technology systems including large-scale outages. Incidents or exposures classified at this level affect critical United Information Systems and will affect United's customers.

(b) **"Medium Severity"** or severity 2 (major impact) means internal loss or exposure of United Information, causing significant business interruption. Incidents or exposures classified at this level affect non-critical United Information Systems and may affect United's customers.

(c) **"Low Severity"** or severity 3 (moderate impact) means loss or exposure of United public information, causing a limited or confined business interruption. Incidents or exposures classified at this level affect United Information Systems or assets, but do not affect United's customers.

1.2 **"United Information"** includes Confidential Information of United as such is or may be defined in the Agreement, Non-Public Personal Public Information, as defined under the Gramm-Leach-Bliley Act and implementing regulations ("GLB"), as well as Protected Health Information and Electronic Protected Health Information, as such terms are defined in 45 CFR Parts 160 and 164 (or successor regulations).

1.3 **"United Information Systems"** means information systems resources supplied or operated by United or its contractors (excluding Vendor and its subcontractors), including without limitation, network infrastructure, computer systems, workstations, laptops, hardware, software, databases, storage media, proprietary applications, printers, and internet connectivity which are owned, controlled or administered by or on behalf of United.

1.4 **"Vendor Processing"** means any information collection, storage or processing performed by Vendor or its contractors: (i) which directly or indirectly supports the services or functions now or hereafter furnished to United under the Agreement, (ii) using any United Information, or (iii) in respect of any other information if performed on behalf of United or in support of United's business, operations or services.

1.5 **"Vendor Processing Resources"** means information processing resources supplied or operated by Vendor, including without limitation, network infrastructure, computer systems, workstations, laptops, hardware, software, databases, storage media, printers, proprietary applications, internet connectivity, printers and hard copies which are used, either directly or indirectly, in support of Vendor processing.

SECTION 2
SECURITY MANAGEMENT

2.1 **Vendor Security Contact.** Vendor shall provide a security representative as the single point of contact for United on all security issues, who shall be responsible for overseeing compliance with this Exhibit.

2.2 **Policies and Procedures.** Vendor shall maintain written security management policies and procedures to prevent, detect, contain, and correct violations of measures taken to protect the confidentiality, integrity, availability, or security of Vendor Processing Resources and/or United Information. Such policies and procedures shall: (i) assign specific data security responsibilities and accountabilities to specific individual(s); (ii) include a formal risk management program which includes periodic risk assessments; and (iii) provide an adequate framework of controls that safeguard United Information Systems and United Information.

2.3 **Infrastructure Protection.** Vendor shall maintain industry standard procedures to protect Vendor Processing Resources, including, at a minimum:

(a) Formal security programs (policies, standards, processes, etc.);

(b) Processes for becoming aware of, and maintain, security patches and fixes;

(c) Router filters, firewalls, and other mechanisms to restrict access to the Vendor Processing Resources, including without limitation, all local site networks which may be accessed via the Internet (whether or not such sites transmit information);

(d) Resources used for mobile access to United Information Systems shall be protected against attack and penetration through the use of firewalls; and

(e) Processes to prevent, detect, and eradicate malicious code (e.g., viruses, etc.) and to notify United of instances of malicious code detected on Vendor Processing Resources or affecting United Information.

SECTION 3
RISK MANAGEMENT

3.1 **General Requirements.** Vendor shall maintain appropriate safeguards and controls and exercise due diligence to protect United Information and Vendor Processing Resources against unauthorized access, use, and/or disclosure, considering all of the below factors. In the event of any conflict or inconsistency, Vendor shall protect the United Information and Vendor Processing Resources in accordance with the highest applicable requirement:

(a) Federal, state, legal and regulatory requirements;

(b) Information technology and healthcare industry best practices;

(c) Sensitivity of the data;

(d) Relative level and severity of risk of harm should the integrity, confidentiality, availability or security of the data be compromised, as determined by Vendor as part of an overall risk management program;

(e) United's data security requirements, as set forth in this Exhibit, the due diligence process and/or in the Agreement; and

(f) Any further information security requirements which are included in a statement of work or equivalent document which is attached to or relates to the Agreement.

3.2 **Security Evaluations.** Vendor shall periodically (no less than annually) evaluate its processes and systems to ensure continued compliance with obligations imposed by law, regulation or contract with respect to the confidentiality, integrity, availability, and security of United Information and Vendor Processing Resources. Vendor shall document the results of these evaluations and any remediation activities taken in response to such evaluations, and provide to United a copy.

3.3 **Internal Records.** Vendor shall maintain mechanisms to capture, record, and examine information relevant to Security Incidents and other security-related events. In response to such events, Vendor shall take appropriate action to address and remediate identified vulnerabilities to United Information and Vendor Processing Resources.

3.4 **United Audits.** Vendor agrees to permit United, its auditors, its customers, or any governmental authority, upon reasonable advance notice, to inspect and examine Vendor Processing Resources, the facilities used to perform Vendor Processing, as well as policies, procedures, plans, and other records and documentation as reasonably necessary for United to verify Vendor's compliance with this Exhibit. United reserves the right to require Vendor to install appropriate systems management and security software to ensure appropriate protection is in place. United shall not disclose any information learned by United in the course of performing any such inspection or examination except as may be reasonably necessary for United to comply with obligations relating to the protection of United Information or as may otherwise be required by law.

3.5 **Remediation.** Vendor will remedy any High Severity security exposure or finding discovered by United within twenty-four (24) hours from the time the finding is identified and notice is provided to Vendor. Vendor will remedy any Medium to Low Severity security exposure or finding discovered by United within two (2) to five (5) business days, from the time the finding is identified and notice is provided to Vendor. If Vendor does not address the exposure or finding within the applicable time obligation, United shall have the right to immediately terminate access to United Information Systems and United Information without penalty to the services related to the access.

3.6 **Audit Practices.** Vendor shall provide to United, at least annually, information on its audit processes, procedures and controls, including a report on any findings and remediation efforts. United may accept, in place of an audit, independent attestation of Vendor's security practices and process controls, provided the attestation provides sufficient evidence (e.g., Statements on Auditing Standards 70 Type II equivalent, etc.).

3.7 **Vendor Locations.** Unless previously authorized by United in writing, all work performed by Vendor related to the Agreement shall be performed from the Vendor location(s) in the United States or any other location designated in the Agreement and/or any relevant statement of work(s), exhibits, lists, grids or documents that United provides to Vendor related to any offshoring requirements or restrictions. For any location(s) outside of the fifty (50) United States ("Offshore Locations") where Vendor performs work related to the Agreement for United, Vendor also agrees to maintain the following security controls:

(a) Vendor shall conduct either a SAS70 Type II Audit, a BS-7799 certification, or an ISO27001 certification at all Offshore Locations from which work is performed by Vendor related to the Agreement and will provide the resulting audit reports to United. The audits or certifications will be conducted once annually, and each report will cover a twelve (12) month term. The audit report will be issued to United no later than sixty (60) days after the audit is completed.

(b) Vendor shall conduct assessments of general control objectives, as defined by United. These objectives may be periodically updated by United, effective upon delivery to Vendor to address additional services that Vendor will provide to United.

(c) Vendor will comply with all future BS-7799 regulations, ISO27001 standards, or that of its successor(s), as issued by the SEC and the Public Company Accounting Oversight Board, British Standards Institute (BSI), or International Standards Organization (ISO).

(d) In the event that Vendor's audit report does not meet United requirements, United may exercise its rights under Section 3.4 of this Exhibit. All costs associated with such audit(s) shall be paid by Vendor.

(e) At United's request, Vendor will provide a quarterly management representation letter reflecting any material changes in the environment utilized for the provided services.

SECTION 4
PERSONNEL SECURITY

4.1 **Access to United Information.** Vendor shall require its employees, contractors and agents who have, or may be expected to have, access to United Information or United Information Systems to comply with the provisions of the Agreement, including this Exhibit, any other exhibits to the Agreement, and any confidentiality agreement(s) or Business Associate Agreement(s) binding upon Vendor. Vendor will remain responsible for any breach of this Exhibit by its employees, contractors, and agents.

4.2 **Security Awareness.** Vendor shall ensure that its employees and contractors remain aware of industry standard security practices and their responsibilities for protecting United Information. This shall include, but not be limited to:

(a) Protection against malicious software (such as viruses);

(b) Appropriate password protection and password management practices; and

(c) Appropriate use of workstations and computer system accounts.

4.3 **Sanction Policy.** Vendor shall maintain a sanction policy to address violations of Vendor's internal security requirements or security requirements which are imposed on Vendor by law, regulation, or contract.

4.4 **Supervision of Workforce.** Vendor shall maintain processes for authorizing and supervising its employees, temporary employees, and independent contractors and for monitoring access to United Information, United Information Systems and/or Vendor Processing Resources.

4.5 **Background Checks.** Vendor shall maintain processes to determine whether a prospective member of Vendor's workforce is sufficiently trustworthy to work in an environment which contains Vendor Processing Resources and United Information. At a minimum, such

processes shall meet the requirements set forth in United's standard background investigations procedures, a copy of which will be provided to Vendor upon request.

SECTION 5
PHYSICAL SECURITY

Vendor shall maintain appropriate physical security controls (including facility and environmental controls) to prevent unauthorized physical access to Vendor Processing Resources and areas in which United Information is stored or processed. Where practicable, this shall include controls to physically protect hardware (e.g., lockdown devices). Vendor shall adopt and implement a written facility security plan which documents such controls and the policies and procedures through which such controls will be maintained. Vendor shall maintain appropriate records of maintenance performed on Vendor Processing Resources and on the physical control mechanisms used to secure Vendor Processing Resources. Vendor shall obtain United's prior written approval prior to moving storage or processing of United Information, or personnel which have access to United Information or United Information Systems, to a location outside the United States.

SECTION 6
SOFTWARE

6.1 **Software Licensing.** Any access provided to Vendor under this Exhibit is limited to United Information and United Information Systems and United is not granting Vendor a license to use the software programs contained within United Information Systems. Any license to the software programs contained within the United Information Systems shall be pursuant to a separate agreement between the parties.

6.2 **Software Usage.** Vendor shall not attempt to reverse engineer or otherwise obtain copies of the software programs contained in United Information Systems. This Exhibit does not transfer Vendor title of any ownership rights or rights in patents, copyrights, trademarks and trade secrets included in United Information Systems.

SECTION 7
SECURITY MONITORING AND RESPONSE

7.1 **Incident Response.** Vendor shall maintain formal processes to detect, identify, report, respond to, and resolve Security Incidents in a timely manner.

7.2 **Incident Notification.** Vendor shall notify United in writing and provide a resolution plan within two (2) hours of any Security Incident(s) which result in, or which Vendor reasonably believes may result in, unauthorized access to, modification of, or disclosure of United Information, United Information Systems or other United applications.

7.3 **Incident Resolution.** After obtaining a written notification and resolution plan, United will determine the severity of the Security Incident and advise Vendor of such severity. If United

considers the risk to be a High Severity exposure, Vendor must resolve or mitigate the High Severity within twenty-four (24) hours of providing such notice. If United considers the exposure a Medium or Low Severity exposure, then Vendor must resolve or mitigate the risk within two (2) to five (5) business days of providing such notice. If Vendor does not resolve the Security Incident within the applicable time obligation, United shall have the right to immediately terminate access to United information and United Information Systems without penalty.

7.4 **Site Outage.** Vendor shall promptly report to United any Vendor site outages where such outage may impact United or Vendor's ability to fulfill its obligations to United.

SECTION 8
COMMUNICATION SECURITY

8.1 **Exchange of Confidential Information.** The parties agree to utilize a secure method of transmission when exchanging Confidential Information electronically.

8.2 **Encryption.** Vendor shall maintain encryption, in accordance with standards mutually agreed upon between the parties, for all transmission of United Information via public networks (e.g., the Internet). Such transmissions include, but are not limited to:

(a) Sessions between web browsers and web servers;

(b) Email containing United Information (including passwords); and

(c) Transfer of files via the Internet (e.g., FTP).

8.3 **Protection of Storage Media.** Vendor shall ensure that storage media containing United Information is properly sanitized of all United Information or is destroyed prior to disposal or re-use for non-Vendor Processing. All media on which United Information is stored shall be protected against unauthorized access or modification. Vendor shall maintain reasonable and appropriate processes and mechanisms to maintain accountability and tracking of the receipt, removal and transfer of storage media used for Vendor Processing or on which United Information has been stored.

8.4 **Data Integrity.** Vendor shall maintain processes to prevent unauthorized or inappropriate modification of United Information, for both data in transit and data at rest.

SECTION 9
ACCESS CONTROL

9.1 **Access Control.** Vendor shall maintain appropriate access control mechanisms to prevent all access to United Information and/or Vendor Processing Resources, except by: (i) specified users expressly authorized by United and (ii) Vendor personnel who have a "need to access" to perform a particular function in support of Vendor Processing. The access and

privileges granted shall be limited to the minimum necessary to perform the assigned functions. Vendor shall maintain processes to ensure that employee or contractor access to Electronic Protected Health Information is revoked no later than within two (2) business days of termination. Vendor shall maintain appropriate mechanisms and processes for detecting, recording, analyzing, and resolving unauthorized attempts to access United Information or Vendor Processing Resources. Notification to United of such unauthorized attempts is set forth in Section 7.2.

9.2 **Identification and Authentication.** All access to any United Information or any Vendor Processing Resources shall be Identified and Authenticated as defined in this Section. "Identification" refers to processes which establish the identity of the person or entity requesting access to United Information and/or Vendor Processing Resources. "Authentication" refers to processes which validate the purported identity of the requestor. For access to United Information or Vendor Processing Resources, Vendor shall require Authentication by the use of an individual, unique user ID and an individual password or other appropriate Authentication technique approved by United in writing. Vendor shall obtain written approval from United prior to using digital certificates as part of Vendor's Identification or Authorization processes. Vendor shall maintain procedures to ensure the protection, integrity, and soundness of all passwords created by Vendor and/or used by Vendor in connection with the Agreement.

9.3 **Account Administration.** Vendor shall maintain appropriate processes for requesting, approving, and administering accounts and access privileges for Vendor Processing Resources and United Information. These processes shall be required for both United-related accounts and Vendor's internal accounts for Vendor Processing Resources, and shall include procedures for granting and revoking emergency access to Vendor Processing Resources and United Information. All access by Vendor's employees or contractors to United Information Systems shall be subject to advance approval by United and shall follow United standard policies and procedures.

SECTION 10
NETWORK SECURITY

10.1 **Authorized Access.** Vendor shall only have access to United Information Systems authorized by United and shall use such access solely for providing services to United. Vendor shall not attempt to access any applications, systems or data that United has not authorized Vendor to access or that Vendor does not need to access in order to perform services for United. Vendor further agrees to access such applications, data and systems solely to the extent minimally necessary to provide services to United. Vendor's attempt to access any applications, data or systems in violation of the terms in this Section 10.1 shall be a material breach of the Agreement.

10.2 **Remote Access Requirements.** In the event United authorizes Vendor to remotely access United Information Systems, Vendor shall only do so only from locations approved by United in writing. These locations may include, but are not limited to, Vendor primary locations, co-locations, employee home offices, and required business travel destinations. Vendor remote

access shall be subject to United security and audit controls as referenced below in sections 10.3 and 10.4.

10.3 **Remote Access Security Controls.** In the event United authorizes Vendor to remotely access United Information Systems, unless authorized by United in writing, only United-owned and maintained mobile/PC devices (i.e., laptops, electronic notebooks, desktop PCs, etc) may be used for remote access into United Information Systems. In the event that United approves Vendor-owned mobile devices or mobile/PC devices for remote access connections, Vendor agrees to the following security controls:

(a) Vendor shall procure mobile/PC devices and related operational hardware, manage the facilities used for remote or at home use, and provide access to United systems.

(b) Vendor shall establish mutually agreed upon policies, procedures and protocols that are to address the facilities requirements for remote or at home access.

(c) Mobile/PC devices shall be routinely registered with the United security guard or the United manager, as required.

(d) Vendor shall have and shall restrict administrative rights to the mobile/PC device and will provide United field support the rights necessary to verify configuration on a periodic basis.

(e) Vendor shall configure the mobile/PC device according to United's connectivity requirements, including approved VPN software.

(f) Vendor shall maintain mobile/PC device password and screen saver safeguards.

(g) Vendor shall disable all wireless capability from the mobile/PC device when not in use.

(h) Vendor shall only use current, commercially supported operating systems on the mobile/PC device.

(i) Vendor shall only use current and up to date patches, hot fixes, and service.

(j) Vendor shall not simultaneously connect to the United network and a non-secure network (third party network or other non-standard connections). Only authorized connections from United Information Systems to United approved networks are allowed.

(k) United reserves the right to require installation of appropriate systems management and security software to ensure adequate protection, including but

not limited to system patch levels, anti-virus and malware protection, software licensing and appropriate device-level firewall protection.

(l) Vendor remote access users shall adhere to United standard authentication protocols including, but not limited to, network and application login accounts, and/or two factor authentication tokens.

(m) Vendor shall remotely connect to United systems using only the following United-provided solutions:

(i) External Corporate Connection through a dedicated private network connection and/or via Virtual Private Network Business To Business Internet Connection ("VPN B2B"), with appropriate firewall rules to restrict connectivity to only required resources, or
(ii) External Corporate Connection Virtual Private Network Client solution to a specified user group to restrict connectivity to only required resources, or
(iii) External Corporate Connection with a CITRIX presentation model, restricting connectivity and access to only required resources.

10.4 **Remote Access Audit Controls.** Unless authorized by United in writing, all contracted work by Vendor shall be conducted from the designated Vendor locations as referenced in the Agreement and/or relevant statement of work(s), exhibits, lists, grids or documents that United provides to Vendor. If United authorizes Vendor personnel to provide services to United remotely, the following audit controls shall apply:

(a) Vendor shall monitor remote or at home users on a periodic basis, which shall include both quarterly onsite audits and a summary report on findings and remediation efforts. Vendor shall provide such reports to United.

(b) Vendor shall follow the additional confidentiality obligations:

(i) Vendor will not remove any United Information from Vendor location(s), and will not print or download any United Information, including information resulting from connectivity or access to a United system(s), without prior approval of United.
(ii) Vendor shall inventory any United Information obtained by Vendor and shall return or destroy United Information as required by United. If requested by United, Vendor shall provide a certificate of secure destruction.
(iii) Vendor will comply with all United policies and procedures regarding the safekeeping of United Information. Policies and procedures must include limitations regarding the storage of information on mobile/PC devices.
(iv) Vendor will keep any hardcopy United Information in a locked file cabinet when such information is not in use.

(v) Vendor will maintain written security management policies and procedures regarding secure possession of United Information when traveling and utilizing United Information in public environments.

SECTION 11
MISCELLANEOUS

11.1 **Software Development.** If the Agreement involves the development of software product(s) for United, such software shall be developed and maintained in accordance with the development methodology specified by United. Such software shall satisfy the appropriate United information security policies and guidelines that are furnished by United to Vendor (which are incorporated herein by reference). Vendor shall comply with any instructions, guidelines or minimum compliance controls that are furnished by United to Vendor (which are incorporated herein by reference) to enable United to comply with the Sarbanes Oxley Act and/or other applicable laws and regulations.

11.2 **Business Continuity Management.** Vendor will, at its sole expense, establish and maintain (i) written business continuity plans for the services and supporting facilities and (ii) written disaster recovery plans for critical technology and systems infrastructure and (iii) proper risk controls (collectively, the "Contingency Plans") to enable continued performance under the Agreement in the event of a disaster or other unexpected break in services. Vendor will update and test the operability of any applicable Contingency Plan at least annually, and will maintain each such plan upon the occurrence of a disaster event. As used herein, a disaster is defined as an unanticipated incident or event, including, without limitation, force majeure events, technological accidents, or human-caused events, that may causes a material service or critical application to be unavailable without any reasonable prediction for resumption, or that causes data loss, property damage or other business interruption without any reasonable prediction for recovery, within a commercially reasonable time period.

11.3 **Compliance with Laws.** Vendor shall comply with all federal, state and local laws, regulations, ordinances and requirements relating to the confidentiality, integrity, availability, or security of United Information applicable to Vendor's obligations under the Agreement, including obligations in this Exhibit or other exhibits to the Agreement, or Business Associate Agreement(s) binding upon Vendor. In relation to and in conjunction with Vendor's obligations under any Business Associate Agreement or HIPAA exhibit, Vendor shall comply with the following with respect to Electronic Protected Health Information:

(a) **Safeguards.** Vendor shall maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of United as required by 45 CFR, Part 164, Subpart C.

(b) **Third Parties.** Vendor shall ensure that any agent, including a subcontractor, to whom Vendor provides Electronic Protected Health Information agrees to

maintain reasonable and appropriate safeguards to protect such Electronic Protected Health Information; provided, however, that Vendor shall not assign, delegate, or subcontract any obligation of Vendor owed to United in violation of the Agreement.

11.4 **Amendments.** This Exhibit may be modified by a written agreement executed by Vendor and United. Notwithstanding the foregoing or anything else, United may amend this Exhibit by providing thirty (30) days advance written notice of such amendment if United reasonably determines that such amendment is necessary for United to comply with the Standards for Privacy of Individually Identifiable Health Information or the Security Standards for the Protection of Electronic Protected Health Information (both of which are set forth at 45 CFR Parts 160 and 164) or any other applicable federal, state or local law, regulation, ordinance, or requirement relating to the confidentiality, integrity, availability, or security of individually identifiable medical or personal information or other United Information.

AMENDMENT NUMBER 2
TO THE ADMINISTRATIVE SERVICES AGREEMENT

This Amendment Number 2 to the Administrative Services Agreement (this "Amendment"), is entered into the later of: (i) January 1, 2018; or (ii) such date as approved by the applicable regulatory agency(ies), (the "Amendment Effective Date") by and between **March Vision Care Group Incorporated** ("Vendor") and **UnitedHealthcare of Louisiana, Inc.** ("United").

WHEREAS, the parties entered into an Administrative Services Agreement effective February 1, 2015 as subsequently amended (the "Agreement") that sets forth the terms and conditions under which Vendor provides and/or arranges for the provision of certain vision services on behalf of United;

WHEREAS, by executing this Amendment, the parties each agree to be bound by those terms and conditions, except where provided for in this Amendment, that make up the main body of the Agreement between the parties.

NOW THEREFORE, in consideration of the conditions set forth herein, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree to amend the Agreement as follows:

1. Capitalized terms used herein which are not otherwise defined in this Amendment or any attachments hereto shall have the meaning assigned to them in the Agreement.

2. The compensation rates listed in Exhibit A shall be deleted and replaced as shown below:

Segment	Line of Business	Service	Service Type	Service Area *	Rate ($)	Rate Type	ASO or Full Service
C&S	Medicare- Dual	UnitedHealthCare - Dual Complete	Vision	LA	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid Adult >\= 21	Vision	LA	[redacted]	PMPM	ASO
C&S	Medicaid	Medicaid Child Less Than 21	Vision	LA	[redacted]	PMPM	ASO

3. The Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix included in the Agreement as Exhibit D is hereby deleted and replaced in its entirety with the version attached hereto.

4. Except as so amended, all other provisions of the Agreement shall remain in full force and effect. Any conflict between the Agreement and this Amendment shall be resolved in favor of this Amendment.

[REST OF THIS PAGE INTENTIONALLY LEFT BLANK FOLLOWED BY THE SIGNATURE PAGE WHICH MAY BE EXECUTED ELECTRONICALLY IN COUNTERPARTS AND SENT VIA FACSIMILE OR EMAIL]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Amendment Effective Date.

March Vision Care Group, Incorporated	**UnitedHealthcare of Louisiana, Inc.**
By: 	By: _____
Print Name: Glenville A. March, Jr., M.D.	Print Name: _____
Print Title: Secretary	Print Title: _____

EXHIBIT D

LOUISIANA MEDICAID AND CHIP PROGRAM
REGULATORY REQUIREMENTS APPENDIX

[SEE ATTACHED]

LOUISIANA MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

MEDICAL SUBCONTRACTOR

THIS LOUISIANA MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the agreement (the "Subcontract") between UnitedHealthcare of Louisiana, Inc. ("United") and subcontractor named in the agreement to which this Appendix is attached (the "Subcontractor").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of indirect or non-health care related services provided by Subcontractor under the State of Louisiana's Healthy Louisiana and related programs (collectively, the "State Program") as governed by the State's designated regulatory agencies. Subcontractor shall comply with all provisions of this Appendix to the extent applicable to Subcontractor's services under the Subcontract. In the event of a conflict between this Appendix and other appendices or any provision of the Subcontract, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Subcontract. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Subcontract is inconsistent with any definitions under the State Program, the definitions shall have the meaning set forth under the State Program.

2.1 **Agreement:** An executed contract between Subcontractor and a Provider for the provision of Covered Services to persons enrolled in the State Program(s).

2.2 **Covered Person(s):** An individual who is currently enrolled with United for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement and/or Subcontract.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.4 **Department or LDH:** The Louisiana Department of Health.

2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement with Subcontractor for the provision of Covered Services to Covered Persons.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United's contract with LDH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana's Healthy Louisiana and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, "State Program" may refer to the State agency(ies) responsible for administering the State Program.

2.9 **Subcontract:** A written agreement between United and Subcontractor to fulfill any requirements of the State Contract.

SECTION 3
OBLIGATIONS OF SUBCONTRACTOR'S PROVIDER

The State Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Covered Persons enrolled in the State Program comply with certain requirements as set forth below and elsewhere in this Appendix. As applicable, Subcontractor shall require its Providers to comply with the requirements set forth below and elsewhere in this Appendix.

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services - and that are needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services also include services defined as such under 42 U.S.C. § 1395dd(e) ("anti-dumping provisions").

(c) Medically Necessary or Medical Necessity: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Although a service may be deemed medically necessary, it does not mean the service will be covered under the State Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

3.2 Accessibility Standards; Hours of Operation; Appointments. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, including Section 7.2, and as further described in the applicable provider manual.

3.3 Antitrust. Provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any State Program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Healthy Louisiana. For purposes of this assignment clause, "Provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries

3.4 Medicaid or CHIP Participation. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in United's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. United will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals

3.6 Electronic Visit Verification (EVV). Subcontractor must, and shall require Provider to use the state-contracted electronic visit verification (EVV) system in accordance with the timeframes set forth in the 21st Century Cures Act and as directed by LDH.

3.7 Health Records. Provider agrees to cooperate with United to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards

3.8 Overpayments. Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment.

3.9 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Subcontractor agrees and shall require Provider to agree that such PIPs must comply with 42 C.F.R. §§ 417.479, 438.3, 422.208, and 422.210 . Neither United, Subcontractor or Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

3.10 Disclosure. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 C.F.R. §§ 455.100-107 and 455.400-470. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 C.F.R. § 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 C.F.R. § 455.434.

Provider shall report to United loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of receipt of notification, if required to be accredited. Provider shall also immediately report cancellation of any required insurance coverage, licensure, or certification to United.

3.11 Cultural Competency and Access. Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired

for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities

3.12 Overpayments. Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment

3.13 Data and Reports. Provider agrees to cooperate with and release to United any information necessary for United to comply with the State Contract and federal and state law, to the extent applicable to Provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters, and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. All reports and data must be provided within the timeframes specified and in a form that meets United and State requirements. By submitting data to United, Provider represents and attest to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.14 Claims Information. Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Provider shall submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

Provider is encouraged, as an alternative to the filing of paper-based claims, to submit and receive claims information through electronic data interchange (EDI).

3.15 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State

and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied. Provider must report loss of accreditation, suspension, or action taken that could result in loss of accreditation, inclusive of all documentation from the accrediting body, within 24 hours of recei9pt of notification, if required to be accredited.

3.16 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with United's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.17 Non-Discrimination. Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability

3.18 Immediate Transfer. Subcontractor shall ensure Provider cooperates with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

3.19 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Subcontractor shall, and shall require Provider to work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

3.20 Continuity of Care. Subcontractor shall, and shall ensure Provider cooperates with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Subcontractor's and/or Provider's participation with United terminates during the course of a Covered Person's treatment by Subcontractor and/or Provider, except in the case of adverse reasons on the part of Subcontractor and/or Provider.

3.21 Advance Directives. Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 489, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.22 National Provider ID (NPI). If applicable, Subcontractor shall, and shall require Provider to obtain a National Provider Identification Number (NPI).

3.23 Termination. In the event of termination of the Agreement, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims.

3.24 Complaints and Appeals. Subcontractor shall, and shall require Provider to comply with United's process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:

(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Subcontractor's and/or Provider's facility(ies) of a Covered Person's right to appeal adverse actions affecting Covered Services in accordance with LDH's rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Subcontractor and/or Provider have a correct and adequate supply of such public notices.

3.25 Health Care-Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to United any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438, and 447.26.

3.26 Penalties; Sanctions. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH has the right to direct United to impose financial consequences against Subcontractor and/or Provider, as appropriate, for Subcontractor's or Provider's failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United's request for information, including credentialing information, or a request to provide medical records.

3.27 Clinical Laboratory Improvements Act (CLIA) certification or waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services

performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services

3.28 Hospital Providers. As applicable, Provider must register all births through LEERS (Louisiana Electronic Event Registration System) administered by the LDH/Vital Records Registry. Hospital Providers must notify United and LDH of the birth of a newborn when the mother is a member of United, complete the web-based LDH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to LDH.

3.29 Mental Health and Substance Use Providers. Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable.

3.30 Long-Term Services and Supports (LTSS) Providers. Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Hold Harmless. Except for any applicable State Program approved cost sharing, Subcontractor shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services ("HHS") and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR §447.15, as may be amended from time to time, the Covered Person is not liable to Provider or Subcontractor for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Neither Subcontractor nor Provider shall require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Subcontractor and Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

If the services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

4.2 Indemnification. Subcontractor shall, and to the extent applicable to Provider in performance of the Agreement, shall ensure Provider indemnifies, defends, and holds LDH and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Subcontractor or Provider, its agents, officers, employees or contractors arising from the Agreement. LDH may waive this requirement for public entities if Subcontractor or Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

4.3 Ownership and Control Information. Subcontractor shall, and shall ensure Provider complies with and submits to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time. Subcontractor and Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Subcontractor and Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Subcontractor and Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

4.4 Record Keeping.

(a) Maintenance. In conformity with requirements under State and federal law and the State Contract, Subcontractor and Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Subcontractor's and Provider's performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Subcontractor and Provider in accordance with the terms and conditions of the State Contract.

(b) Medical Records. Subcontractor shall, and shall ensure Provider retains medical records at the site where medical services are provided. Each Covered Person's medical record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. Subcontractor shall, and shall ensure Provider maintains the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given

access to and can request copies of the Covered Person's medical records, to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, LDH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) Records Access. Subcontractor acknowledges and agrees and shall require Provider to acknowledge and agree that the State, HHS, Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Subcontractor and Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the Subcontractor agrees, and shall require Provider to agree, to not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. Subcontractor and Subcontractor's Provider agrees that this contract creates for the MFCU an enforceable right for which the MFCU can petition the court in the event of non-compliance with an information, records or data request.

Covered Persons and their representatives shall be given access to and can request copies of the Covered Person's medical records to the extent and in the manner provided by La.R.S. § 40:1299.9

(d) Records Retention. As required under State or federal law or the State Contract, Subcontractor shall and shall require Provider to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposal of records must be requested and approved by United if the Agreement is continuous. If Subcontractor and/or Provider store records on microfilm or microfiche or other electronic means, Subcontractor shall, and shall ensure Provider produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

(d) Records Upon Audit. Subcontractor shall require Provider to have online retrieval and access to documents and files for audit and reporting purposes for 10 years in live systems and an additional 4 years in archival systems. Historical encounter data submission shall be retained for a period not less than 10 years, following generally accepted retention guidelines. Services which have a once in a lifetime indicator (i.e., appendix removal, hysterectomy) are denoted on LDH's procedure formulary file, and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID, provider NPI, and/or ICN (internal control number) to include pertinent claims data and claims status. Audit trails shall be maintained online for no less than 6 years. Provider shall provide access to information in machine-readable format within 48 hours of requests for information less than 6 years old and within 72 hours of requests for information greater than 6 years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress or unresolved, information shall be kept in electronic form until all tasks or proceedings are completed. Under no circumstances shall the Provider destroy or dispose of any such records, even after the expiration of the retention periods provided above, without the express prior written permission of LDH

(e) Records Upon Termination. United, Subcontractor and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Subcontractor and Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Subcontractor's and Provider's activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to LDH or its designated representative. The provision of such records shall be at no expense to the Department.

4.5 Government Audit; Investigations.

(a) By State and Federal Agencies. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that LDH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor's Office, the Louisiana Attorney General's Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Subcontractor acknowledges and agrees and shall require Provider to acknowledge and agree that all agencies listed above or any of their designees shall be provided with access to all documents and records related to the program services and the right to examine, evaluate and investigate, including on-site audits and examinations and private interviews of Subcontractor's clients and employees. Subcontractor shall, and shall require Provider to cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as

often as they may deem necessary during the State Contract period and for a period of ten (10) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs with no charge to the agencies listed above.

(b) By LDH. In addition to the above, Subcontractor shall, and shall require Provider to make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of LDH.

(c) Subcontractor shall require Provider to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. Provider agrees that the Agreement creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

(d) Subcontractor shall require Provider to agree that the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Provider, or of the Provider's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under United's contract with the State. Provider will make available, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Covered Persons. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate and audit the subcontractor at any time.

(e) Subcontractor shall require Provider to make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG),

HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

4.6 Privacy; Confidentiality. Subcontractor understands and shall require Providers to agree that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 C.F.R. §§ 160.101 et seq., 162.100 et seq., and 164 et seq., as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 C.F.R. §§ 2.1 et seq., 431.300-307, 434.1 et seq., 438.224 and 438.3 (as applicable).

Subcontractor will require that Provider further acknowledge that, in some cases, Provider will have access to information on individuals with whom Provider has no treatment or other relationship. In such cases Provider will abide by all requirements under HIPAA and ensure that the confidentiality of such information is fully maintained.

Access to member identifying information shall be limited by Subcontractor and/or Provider to persons or agencies that require the information in order to perform their duties in accordance with the Agreement and Subcontract, including the HHS, the Department and other individuals or entities as may be required. Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Subcontractor and Provider are responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA

regulations. Subcontractor shall, and shall require Provider to notify United and LDH of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the LDH with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Subcontractor and/or Provider shall work with United and LDH to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

4.7 Compliance with Laws, State Contract, MCO Manual and LDH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract, MCO Manual and LDH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and LDH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider may also access these documents on the LDH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.

4.8 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall require Provider to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor or Provider in their performance of the Subcontract and Agreement. Subcontractor and Provider understand that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Subcontractor's or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor and Provider understand and agree that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Subcontractor shall require Provider to agree that they will provide medical records to United upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

4.9 Provider Selection. To the extent applicable to Subcontractor and Provider in performance of the Agreement, Subcontractor shall, and shall require Provider to comply with 42 CFR § 438.214, as may be amended from time to time, which includes but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

If United delegates credentialing to Subcontractor, United will provide monitoring and oversight and Subcontractor shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

4.10 Subcontracts. If Subcontractor or Provider subcontracts or delegates any functions of the Subcontract or Agreement, in accordance with the terms of the Subcontract or Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. Subcontractor and Provider further agree to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

4.11 Lobbying. Subcontractor agrees, and shall require Provider to agree to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Subcontractor and/or Provider certifies to the best of Subcontractor's and Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 CFR § 93, 100 et seq., as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Subcontractor's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Subcontractor and/or Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

4.12 Excluded Individuals. Subcontractor certifies, and shall require Provider to certify to the best of their knowledge and belief that neither it nor any of its principals, nor any Providers, subcontractors or consultants with whom Subcontractor and/or Provider contracts for items or services that are significant and material to Subcontractor's and/or Provider's obligations under the Agreement, is:

(a) excluded from participation in federal health care programs under 42 U.S.C. § 1320a-7; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549, or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Subcontractor is obligated, and shall obligate Provider to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Subcontractor shall not, and shall ensure Provider shall not employ or contract with an individual or entity that has been excluded. Subcontractor shall, and shall require Provider to immediately report to United any exclusion information discovered. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that civil monetary penalties may be imposed against Subcontractor and/or Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Subcontractor and Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and the Excluded Parties List Serve (EPLS) http://www.epls.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. United will exclude from its network any provider who has been excluded from the Medicare, Medicaid or CHIP program in any state. United may also terminate the Agreement if Subcontractor or Provider or Subcontractor's or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

4.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Subcontractor and/or Provider as related to the State Program and performance of the Subcontract and Agreement must be submitted to United to submit to the Department for prior approval..

4.14 Fraud, Abuse, and Waste Prevention. Subcontractor shall, and shall require Provider to cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Subcontractor shall, and shall also require Provider to cooperate with and assist LDH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United's network, employees, Subcontractors, or subcontractors of Provider. Subcontractor shall, and shall require Provider to report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA), Subcontractor shall, and shall require Provider to have written policies for its employees, contractors or agents that: (a) provide detailed information about the False Claims Act (established under sections 31 U.S.C. §§ 3729 - 3733), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 C.F.R. § 438.600; (b) cite administrative remedies for false claims and statements established by 31 U.S.C. § 3801 et seq and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)), include as part of such written policies, detailed provisions regarding Subcontractor's and/or Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Subcontractor agrees, and shall require Provider to agree to train its staff on the aforesaid policies and procedures.

4.15 Acknowledgement Regarding Funds. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that funds paid to Subcontractor and/or Provider under the Agreement are derived from State and federal funds pursuant to the State Contract. Subcontractor further acknowledges and agrees, and shall require Provider to acknowledge and agree that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Subcontractor agrees, and shall require Provider to agree to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

4.16 Electronic Health Records. Subcontractor shall, and shall require Provider to participate in LDH's endeavor to move toward meaningful use of Electronic Health Records. An "Electronic Health Record" is a computer-based record containing health care information. Provider is encouraged to adopt certified electronic health record technology (CEHRT) and comply and attest with its corresponding meaningful use requirements and deadlines as outlined by CMS and the Office of the National Coordinator (ONC). If Provider is an emergency departments (EDs), Provider agrees and is required to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in identification of and creation of policies around high utilizers, drug seeking behavior, and chronic disease management. The visit registry would consist of three basic attributes: (a) the ability to capture and match patients based on demographics information, (b) the ability to identify the facility at which care is being sought, and (c) at minimum, the chief complaint of the visit. These three pieces of information are commonly available through the HL7 ADT message standard and in use by most ED admission systems in use today across the country.

4.17 Insurance Requirements. Before commencing the provision of services under the Agreement, Subcontractor shall, and shall require Provider to obtain, and maintain throughout the term of the Agreement: (a) Workers' Compensation Insurance for all of Subcontractor's and Provider's employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Subcontractor shall, and shall require Provider to furnish United with written verification of the existence of such coverage prior to execution of the Agreement. LDH

and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Subcontractor and Provider; the payment of such a deductible shall be the sole responsibility of Subcontractor and/or Provider. Subcontractor shall and shall require that Provider immediately report cancellation of any required insurance coverage, licensure, or certification to United.

4.18 Ownership and Control Information. Subcontractor shall, and shall require Provider to comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

4.19 Subcontracts; Assignment. Subcontractor shall not, and shall ensure Provider does not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United. If Subcontractor or Provider receives consent, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Subcontractor and/or Provider as applicable agree to promptly amend agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

4.20 Term; Service Standards. All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Subcontractor and Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Subcontractor acknowledges and agrees, and shall require Provider to acknowledge and agree that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

4.21 Refusal Not Permitted. Subcontractor may not, and shall ensure Provider does not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Subcontractor and Provider shall not be required to accept or continue treatment of a Covered Person with whom Subcontractor and Provider feel Subcontractor and Provider cannot establish and/or maintain a professional relationship.

4.22 Payment Submission. Subcontractor will, and will require Provider to promptly submit complete and accurate claims information required for payment and/or LDH-required reports. Subcontractor shall, and shall require Provider to submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

If Provider discovers an error or a conflict with a previously adjudicated encounter claim, Subcontractor and/or Health Plan shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or if circumstances exist that prevent

Subcontractor and/or Health Plan from meeting this time frame a specified date shall be approved by LDH.

When Subcontractor has entered into an alternative reimbursement arrangement with Provider, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the Subcontractor.

4.23 Notice of Adverse Actions. Subcontractor shall, and shall require Provider to give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Subcontractor's or Provider's ability to perform its obligations under the Agreement.

4.24 State Custody. Subcontractor is not permitted, and shall ensure Provider does not encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by LDH.

4.25 Services. Subcontractor shall, and shall require Provider to perform those services set forth in the Agreement. Subcontractor represents, and shall require Provider to represent that the services to be provided by Subcontractor and/or Provider pursuant to the Agreement are within the amount, duration, and scope of benefits and services of Subcontractor's and/or Provider's practice.

4.26 Conflict of Interest. Subcontractor represents and covenants, and shall require Provider to represent and covenant that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Subcontractor further convents, and shall require that Provider covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

4.27 Compliance with Medicaid Laws and Regulations. Subcontractor agrees, and shall require Provider to agree to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Subcontractor and Provider in Subcontractor's and/or Provider's performance of the Subcontract and Agreement. Subcontractor understands, and shall require Provider to agree that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Subcontractor's and/or Provider's compliance with all applicable conditions of participation in Medicaid. Subcontractor understands and shall ensure Provider understands and agrees that each claim the Subcontractor and/or Provider submits to United constitutes a certification that the Subcontractor and/or Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Subcontractor and Provider stipulate that Louisiana law, without regard to its conflict of laws provision, will prevail if there is a conflict between the state law where the material contractor is based and Louisiana law. Subcontractor shall require that Provider agrees that Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs Subcontractor's and/or Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

4.28 Homeland Security Considerations. In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

4.29 Healthcare Oversight Agency Compliance. Subcontractor shall, and shall require Providers to comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities that manage or coordinate certain benefits for Medicaid beneficiaries on behalf of United but do not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and United, Subcontractor or Provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. United, Subcontractor and/or Provider agree that the State Contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

SECTION 5
UNITED REQUIREMENTS

5.1 Prompt Payment. United shall pay Subcontractor pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the State Contract.

If LDH discovers an error or a conflict with a previously adjudicated encounter claim, United will adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH.

5.2 No Incentives to Limit Medically Necessary Services. United shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not

interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

5.4 Communication with Covered Persons. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Subcontractor under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Subcontractor's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Subcontractor in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Subcontract shall be performed in accordance with the requirements of the State Contract and LDH issued guides, the applicable provisions of which are incorporated into the Subcontract by reference. Nothing in the Subcontract relieves United of its responsibility under the State Contract. If any requirement or provision of the Subcontract or this Appendix is determined by LDH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Subcontract or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Subcontract and this Appendix shall remain in full force and effect.

6.2 Monitoring. United shall perform ongoing monitoring (announced or unannounced) of services rendered by Subcontractor under the Subcontract and shall perform periodic formal

reviews of Subcontractor according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or LDH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Subcontractor any deficiencies or areas for improvement mandated under the State Contract and Subcontractor and United shall take appropriate corrective action. Subcontractor shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Subcontractor shall monitor and report the quality of services delivered under the Subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Subcontractor practice and/or the performance standards established under the State Contract.

6.3 Entire Agreement; Incorporation of Applicable Law; Modifications. The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Subcontractor, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Subcontractor. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

6.4 Independent Contractor Relationship. Subcontractor expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of LDH or the State. Subcontractor further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor and LDH or the State.

6.5 Utilization Management Compensation. In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

6.6 Delegated Activities. Any activities delegated to Subcontractor by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Subcontractor and provide for revoking delegation or imposing other sanctions if Subcontractor's performance is inadequate. Prior to delegating any activities to Subcontractor under the State Contract, United will evaluate Subcontractor's ability to perform such activities.

6.7 State Approval. United and Subcontractor acknowledge that LDH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the

State Contract. United will submit and obtain prior approval from LDH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Subcontractor acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of LDH, as are any amendments or subsequent material modifications to the Agreement.

6.8 Dispute Resolution. Subcontractor and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

6.9 No Barriers to Access Covered Services. Neither United nor Subcontractor shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Subcontractor's compliance with this requirement and will implement a corrective action plan within thirty (30) days if Subcontractor's compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.

6.10 Payment. The method and amount of compensation paid to Subcontractor for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Subcontractor acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Subcontractor -initiated request has been submitted to and approved by LDH. United shall not propose to Subcontractor reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Subcontractor may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Subcontractor, United will be responsible for third party collections in accordance with the terms of the State Contract.

In addition, United agrees to comply with the claims processing requirements in the State Contract. At a minimum, United shall run 1 provider payment cycle per week, on the same day each week, as determined by United. United shall support a CAQH/CORE compliant interface to the automated clearinghouse (ACH) that allows providers to request and receive electronic funds transfer (EFT) of claims payments. United shall encourage that its providers submit and receive claims information through electronic data interchange (EDI) as an alternative to the filing of paper-based claims. Claims shall be processed in adherence to information exchange and data management requirements specified in the State Contract. United shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud, abuse, or waste or otherwise included on the Department of Health and Human

Services Office of Inspector General exclusions list, or employs someone on this list. United shall not pay any claim submitted by a provider that is on payment suspension and/or withhold under the authority of LDH or its authorized agent(s). United shall inform all network providers about Clean Claim requirements. United shall make requirements and guidelines for claims coding and processing that are specific to Provider types available to network providers. United shall notify providers 90 calendar days before implementing changes to claims coding and processing guidelines, or as soon as possible if directed by LDH pursuant to state or federal law to implement such change earlier.

6.11 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

6.12 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider's patient for any the following:

(a) The Covered Person's health status, medical care, or treatment options for the Covered Person's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.13 Enrollment. The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.14 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Subcontractor from entering into a contract with another Health Plan or other managed care entity.

6.15 No Exclusivity. Nothing in the Subcontract or this Appendix shall be construed as prohibiting or penalizing Subcontractor for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other subcontractors or providers.

6.16 No Contracting with Exclusive Subcontractor. United shall not have a contract arrangement with any subcontractor provider in which the subcontractor represents or agrees that it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another subcontractor.

6.17 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service subcontractor.

UnitedHealthcare of Louisiana, Inc.

Statutory Basis Financial Statements as of and
for the Years Ended December 31, 2018 and 2017,
Supplemental Schedules as of and for the
Year Ended December 31, 2018,
Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE OF LOUISIANA, INC.

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INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of Louisiana, Inc.
3838 North Causeway Boulevard, Suite 2600
Metairie, LA 70002

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of Louisiana, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2018 and 2017, 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 Louisiana Department of Insurance. 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 audit 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 of Louisiana, Inc. as of December 31, 2018 and 2017, 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 Louisiana Department of Insurance 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 of Louisiana, Inc. using accounting practices prescribed or permitted by the Louisiana Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Louisiana Department of Insurance. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2018 audit was conducted for the purpose of forming an opinion on the 2018 statutory basis financial statements as a whole. The supplemental schedule of investment risks interrogatories and the supplemental summary investment schedule, as of and for the year ended December 31, 2018 are presented for purposes of additional analysis and are not a required part of the 2018 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 2018 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 2018 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 of Louisiana, Inc. 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 3, 2019

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2018 AND 2017

	2018	2017
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 231,956,414	$ 221,519,160
Cash of $1,189,038 and $134,780, and cash equivalents of $123,843,352 and $126,078,382 in 2018 and 2017, respectively	125,032,390	126,213,162
Subtotal cash and invested assets	356,988,804	347,732,322
OTHER ASSETS:		
Investment income due and accrued	2,323,291	1,915,002
Premiums and considerations	182,353,026	154,577,982
Amounts recoverable from reinsurers	271,846	24,539,372
Amounts receivable relating to uninsured plans	274,040	58,172
Net deferred tax asset	14,591,450	16,791,655
Health care receivables	10,137,230	10,603,961
Other assets	231	19,157
Subtotal other assets	209,951,114	208,505,301
TOTAL ADMITTED ASSETS	$ 566,939,918	$ 556,237,623
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 242,105,849	$ 199,078,836
Accrued medical incentive pool and bonus amounts	4,909,576	32,601,316
Unpaid claims adjustment expenses	1,351,967	1,370,586
Aggregate health policy reserves	79,492,787	99,833,192
Aggregate health claim reserves	2,588,118	2,373,673
Premiums received in advance	177,316	111,594
General expenses due or accrued	55,596,719	46,849,407
Current federal income taxes payable	18,724,065	10,911,691
Ceded reinsurance premiums payable	165,808	9,794,140
Remittances and items not allocated	161	-
Amounts due to parent, subsidiaries, and affiliates, net	11,555,554	4,098,941
Liability for amounts held under uninsured plans	24,205	-
Total liabilities	416,692,125	407,023,376
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	-	45,339,570
Common capital stock, $2 par value — 1,000,000 shares authorized; 900,000 shares issued and outstanding	1,800,000	1,800,000
Gross paid-in and contributed surplus	67,138,440	67,138,440
Unassigned surplus	81,309,353	34,936,237
Total capital and surplus	150,247,793	149,214,247
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 566,939,918	$ 556,237,623

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

	2018	2017
REVENUES:		
Net premium income	$ 2,254,982,771	$ 1,981,612,830
Change in unearned premium reserves and reserve for rate credits	(2,696,722)	25,144,313
Total revenues	2,252,286,049	2,006,757,143
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	1,204,185,537	1,096,153,276
Other professional services	23,131,909	23,220,508
Prescription drugs	331,057,520	320,960,965
Full Medicaid pricing pass through	346,377,610	303,331,342
Incentive pool, withhold adjustments, and bonus amounts	(15,535,553)	20,409,463
Net reinsurance payments (recoveries)	6,663,928	(155,212,154)
Total hospital and medical	1,895,880,951	1,608,863,400
Claims adjustment expenses	88,909,905	75,489,675
General administrative expenses	272,302,597	173,362,821
(Decrease) increase in reserves for accident and health contracts	(438,000)	66,876,000
Total underwriting deductions	2,256,655,453	1,924,591,896
NET UNDERWRITING (LOSS) GAIN	(4,369,404)	82,165,247
NET INVESTMENT GAINS:		
Net investment income earned	6,835,785	4,060,655
Net realized capital (losses) gains less capital tax (benefit) of ($16,237) and $31,398 in 2018 and 2017, respectively	(80,370)	37,857
Total net investment gains	6,755,415	4,098,512
NET LOSS FROM AGENTS' OR PREMIUM BALANCES CHARGED OFF	(85,730)	(1,559,331)
OTHER LOSSES	(295,000)	(495,500)
NET INCOME BEFORE FEDERAL INCOME TAXES	2,005,281	84,208,928
FEDERAL INCOME TAXES INCURRED	9,072,302	51,854,275
NET (LOSS) INCOME	$ (7,067,021)	$ 32,354,653

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
		Shares	Amount			
BALANCE — January 1, 2017	$ -	900,000	$ 1,800,000	$ 67,138,440	$ 52,227,169	$ 121,165,609
Net income	-	-	-	-	32,354,653	32,354,653
Change in net deferred income taxes	-	-	-	-	13,641,271	13,641,271
Change in nonadmitted assets	-	-	-	-	(5,947,286)	(5,947,286)
Section 9010 ACA subsequent fee year assessment	45,339,570	-	-	-	(45,339,570)	-
Dividend paid	-	-	-	-	(12,000,000)	(12,000,000)
BALANCE — December 31, 2017	45,339,570	900,000	1,800,000	67,138,440	34,936,237	149,214,247
Net loss	-	-	-	-	(7,067,021)	(7,067,021)
Change in net unrealized capital losses less capital gains benefit of ($13)	-	-	-	-	(49)	(49)
Change in net deferred income taxes	-	-	-	-	(2,200,218)	(2,200,218)
Change in nonadmitted assets	-	-	-	-	(12,472,166)	(12,472,166)
Correction of error (Note 2)	-	-	-	-	22,773,000	22,773,000
Section 9010 ACA subsequent fee year assessment	(45,339,570)	-	-	-	45,339,570	-
BALANCE — December 31, 2018	$ -	900,000	$ 1,800,000	$ 67,138,440	$ 81,309,353	$ 150,247,793

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2018 AND 2017

	2018	2017
CASH FLOWS FROM OPERATIONS:		
Premiums collected — net of reinsurance	$ 2,217,018,781	$ 1,954,030,856
Net investment income	9,342,955	5,414,830
Benefit and loss related payments	(1,867,562,889)	(1,582,655,928)
Operating expenses paid	(352,744,638)	(286,708,843)
Federal income taxes paid — net	(1,243,692)	(34,054,463)
Net cash provided by operations	4,810,517	56,026,452
CASH FLOWS FROM INVESTMENTS:		
Proceeds from bonds sold, matured, or repaid	36,430,685	28,446,791
Cost of bonds acquired	(49,879,025)	(154,283,511)
Net gains (losses) on cash equivalents and short-term investments	275	(9)
Net cash used in investments	(13,448,065)	(125,836,729)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash provided through net transfers from affiliates	7,456,613	1,148,958
Dividend paid	-	(12,000,000)
Other cash provided	163	-
Net cash provided by (used in) financing and miscellaneous activities	7,456,776	(10,851,042)
RECONCILIATION OF CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:		
NET CHANGE IN CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:	(1,180,772)	(80,661,319)
CASH, CASH EQUIVALENT, AND SHORT-TERM INVESTMENTS — Beginning of year	126,213,162	206,874,481
CASH AND CASH EQUIVALENTS — End of year	$ 125,032,390	$ 126,213,162

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of Louisiana, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of 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 April 9, 1986, as an HMO and operations commenced in November 1986. The Company is certified as an HMO, by the Louisiana Department of Insurance ("LADOI"). The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees.

The Company offers comprehensive commercial products to individual and employer groups. Each contract outlines the coverage provided and renewal provisions. Effective January 1, 2017, the Company exited the Affordable Care Act ("ACA") individual exchange market in Louisiana.

Effective January 2018, the Company serves as a plan sponsor offering Medicare Advantage and Medicare Part D prescription drug insurance coverage (collectively "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.

During 2011, the Company was awarded a statewide Medicaid coordinated care network shared savings contract. This was an administrative services only ("ASO") contract. The Company was a primary care case manager that provided enhanced primary care case management in addition to being the entity contracting with primary care providers ("PCP") for PCP care management (see Note 18). Effective February 1, 2015, this contract with the State of Louisiana, Louisiana department of health, was converted into the Medicaid fully insured business to provide health care services to Medicaid and eligible beneficiaries. The current contract is effective through December 31, 2019, and is subject to an annual renewal provision thereafter.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed and permitted by the LADOI.

The LADOI recognizes only statutory accounting practices, prescribed or permitted by the State of Louisiana, for determining and reporting the financial condition and results of operations of an HMO for determining its solvency under Louisiana 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 or permitted by the State of Louisiana and the NAIC SAP which materially affect the statutory basis net (loss) income and capital and surplus, as illustrated in the table below:

Net (Loss) Income	SSAP #	AFS Line	2018	2017
(1) Company state basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	$ (7,067,021)	$ 32,354,653
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ (7,067,021)	$ 32,354,653
Capital and Surplus				
(5) Company state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	$ 150,247,793	$ 149,214,247
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 150,247,793	$ 149,214,247

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 hospital and medical benefits, claims unpaid, aggregate health policy reserves (including medical loss ratio rebates and premium deficiency reserves), aggregate health claim reserves, 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 (loss) 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 or permitted by the LADOI. 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 are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory

convertible securities or Securities Valuation Office of the NAIC ("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 are valued and reported using market prices published by the SVO in accordance with the NAIC Valuation of Securities manual prepared by the SVO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(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 holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no 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 health policy reserves 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 as a decrease (increase) in reserves for accident and health contracts 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. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the statutory basis statements of operations. 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 unpaid CAE 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, 2018 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) The Company does not carry any fixed assets on the statutory basis financial statements;

(13) Health care receivables 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 pharmaceutical benefit manager, OptumRx, Inc. ("OptumRx"). Health care receivables 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 receivables 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;

- Cash and cash equivalents 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;

- The Company has no short-term investments;

- Cash represents cash held by the Company in operating accounts. Claims and other payments are made from the operating accounts daily;

- 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. Cash equivalents have original maturity dates of three months or less from the date of acquisition and are reported at cost or amortized cost depending on the nature of the underlying security, which approximates fair

value. 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 ("NAV") as a practical expedient;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital (losses) gains less capital gains tax (benefit) in the statutory basis statements of operations;

- 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 (losses) gains less capital gains tax (benefit) 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 an other-than-temporary impairment ("OTTI") of $1,550 and $0 for the years ended December 31, 2018 and 2017, respectively.

- The statutory basis statements of cash flows reconcile cash, cash equivalents and short term investments, with original maturities of one year or less from the time of acquisition; whereas under GAAP, pursuant to Accounting Standards Update 2016-18, *Statement of Cash Flows, Restricted Cash*, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash 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 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. Effective for the 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. 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 (see Note 24);

b) CMS risk corridor receivables for which adjustments are based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare program plan varies more than 5% above the level estimated in the original bid submitted by the Company and approved by CMS (see Note 24);

c) CMS risk adjustment receivables. The risk adjustment model apportions premiums paid to all health 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 (see Note 24); and

d) Premium withhold receivables for a Medicaid performance guarantees. The pay for performance program is based upon the Company's performance against various quality and operational measures established in the Company's contract with the State which is based on a stated percentage of total direct premiums written. Premium adjustments for the Medicaid performance guarantee program are accounted for as premium adjustments subject to redetermination (see Note 24).

Premium adjustments for the CMS risk corridor programs are accounted for as premium adjustments subject to retrospectively rated features (see Note 24). 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 operating expenses paid within net cash provided by operations in the statutory basis statements of cash flows. 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. Related cash flows are presented within operating 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.

- **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.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include 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, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These 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 2018 and 2017. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2018; however, actual payments may differ from those established estimates.

  The reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

  The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

  The Company has a contract with the Department of Health and Hospitals ("DHH") in which the Company processes Full Medicaid Pricing ("FMP") payments to specified providers where the FMP has agreements. The Company records both the amounts collected from the DHH and the amounts disbursed to providers, excluding FMP related premium tax, as net premium income and hospital and medical expense, respectively, in the statutory basis statements of operations. Unsettled FMP payments owed to providers, net of premium tax, of $89,367,001 and $70,256,370 is included in claims unpaid as of December 31, 2018 and 2017, respectively, in the statutory basis statements of admitted assets, liabilities and capital and surplus.

- **Accrued Medical Incentive Pool and Bonus Amounts** — 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 accrued medical incentive pool and bonus amounts 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 accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Aggregate Health Policy Reserves** — The Company establishes a liability, net of ceded reinsurance, for estimated premium refunds on experience rated contracts based on the actuarial method and assumptions and minimum loss ratio requirements.

  Aggregate health policy reserves also includes:

  a) 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. Effective for the 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. 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);

  b) 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);

  c) Healthy Louisiana Medicaid estimated payables for the Value Added Benefits and Services program (see Note 24); and

  d) the estimated amount for premium deficiency reserves (see Note 30).

- **Premiums Received in Advance** — Premiums received in full during the current period that are not due until future periods are recorded as premiums received in advance in the statutory basis statements 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. General expenses due or accrued also include the amounts for unpaid assessments, premium taxes, and the unpaid portion of the contributions required under the ACA risk adjustment and reinsurance programs (see Note 24).

- **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).

- **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.

- **Amounts Due 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 due 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 CGDP program. 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 operating 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.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets** — Certain assets, including certain aged premium receivables, certain health care receivables and, prepaid expenses, 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 $1,000,000 as of December 31, 2018 and 2017, respectively, in compliance with the State of Louisiana requirements for qualification purposes as a domestic 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 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 Louisiana, the LADOI, requires the Company to maintain a minimum capital and surplus equal to $3,000,000. The Company has $150,247,743 and $149,214,247 in total statutory basis capital and surplus as of December 31, 2018 and 2017, respectively, which is in compliance with the required amount.

Risk-based capital ("RBC") is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The LADOI 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 in compliance with the required amount.

- **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 2019 Health Insurer Fee ("HIF") moratorium, no HIF will be payable in 2019, therefore no amounts were apportioned out of unassigned surplus in the 2018 statutory basis statements of admitted assets, liabilities, and capital and surplus.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Unearned Premium Reserves and Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the statutory basis statements of operations.

  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 change in unearned premium reserves and reserve for rate credits 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 adjustment balances which are reflected in change in unearned premium reserves and reserve for rate credits and net premium income, respectively, in the statutory basis statements of operations.

  Net premium income includes premium under the Medicare Advantage program, which includes CMS premium. It also 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. Net premium income is recognized ratably over the period in which eligible individuals are entitled to receive health care services and prescription drug benefits.

  Net premium income also includes amounts pursuant to the CMS risk adjustment program. The Company recognized $0 for changes in prior year Medicare risk factor estimates during the year ended December 31, 2018, which is recorded as net premium income 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 change in unearned premium reserves and reserve for rate credits 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 change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

Net premium income 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 the Medicaid program. 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. Included in net premium income are capitated payments, home nursing risk-sharing payments, high-dollar risk pool payments, and maternity payments. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

The Medicaid plan is subject to experience rebates, risk adjustments, and performance guarantees based on various utilization measures. The Company has reported its estimated risk adjustments and experience rebates as change in unearned premium reserves and reserve for rate credits in the statutory basis statements of operations.

- **Full Medicaid Pricing Pass Through** — The DHH and the Company entered into a contract effective February 1, 2015 in which the Company processes FMP payments to specified providers where the FMP has agreements. Once received for the DHH, the Company disburses funds from an allocated pool to hospitals, physician groups, and ambulance groups, less any premium taxes. The funds that have been received cannot be directly linked to a specific claim. Additionally, the Company has no obligation to pay the specified providers until funds have been received. The amounts collected, net of tax, are included in net premium income in the statutory basis statements of operations. FMP receipts of $346,377,610 and $303,331,342 were recorded to net premium income and other medical expenses as of December 31, 2018 and 2017 respectively.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses 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, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the statutory basis statements of operations.

- **General Administrative 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 GAE to be reported in the statutory basis statements of operations.

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 during the calendar year, 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 GAE 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.

Administrative fee revenues consist of gain share provisions from the Company's ASO contract. Administrative fee revenue and related expenses are netted against GAE in the statutory basis statements of operations (see Note 18).

- **Net Investment Income Earned** — Net investment income earned 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 earned (see Note 7).

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% in 2018 and 35% in 2017 to net income before federal income taxes and net realized capital (losses) 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 net premium income in the statutory basis statements of operations. Any amounts due to the Company pursuant to this agreement are recorded as amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 23).

  The Company has an insolvency-only reinsurance agreement with UnitedHealthcare Insurance Company ("UHIC"), an affiliate, whereby 0.01% of net premium income is ceded to UHIC.

- **Amounts Recoverable from Reinsurers** — The Company records amounts recoverable from reinsurers for claims paid pursuant to the reinsurance agreement with Unimerica Insurance Company, Inc. in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as net reinsurance recoveries in the statutory basis statements of operations.

- **Section 1341 ACA Transitional Reinsurance** — The Company has established receivables of $45,860 and $1,596,494 as of December 31, 2018 and 2017, respectively, pursuant to Section 1341 of the ACA which are included in amounts recoverable from reinsurers, a reduction to claims unpaid in the statutory basis statements of admitted assets, liabilities, and capital and surplus, for the transitional reinsurance program. 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).

- **Ceded Reinsurance Premiums Payable —** The ceded reinsurance premiums payable balance represents amounts due to the reinsurers for specified coverage which will be paid based on the contract terms.

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 no commercial customers that individually exceed 10% of total direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, for the years ended December 31, 2018 and 2017.

  Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from members and CMS related to Medicare Advantage and the Medicare Part D program as a percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are 0.2% and below 0.1% as of December 31, 2018.

  Direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, from the State of Louisiana, as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are 98% and 99% as of December 31, 2018 and 97% and 99% as of December 31, 2017, respectively.

Recently Issued Accounting Standards — The Company reviewed all other recently issued guidance in 2018 and 2017 that has been adopted for 2018 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

During 2018, the Company determined that it had overstated in aggregate health policy reserves and increase in reserves for life and accident and health contracts related to premium deficiency reserves by $22,773,000 for the year ended December 31, 2017. In addition, the deferred tax asset as a result of this error was overstated by $4,782,330 for the year ended December 31, 2017. Had the above adjustment been recorded to the 2017 statutory basis financial statements, the increase/(decrease) to net income, total capital and surplus, total assets and total liabilities would have been $22,773,000, $17,990,670, $(4,782,330), and $(22,773,000), respectively. Due to the significance of the error, the cumulative effect of the net income and deferred tax asset of this prior year error was corrected by the Company in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 3, *Accounting Changes and Corrections of Errors*, and is reflected in the statutory basis statements of changes in capital and surplus as a correction of error and change in net deferred income tax, respectively, for the period ended December 31, 2018.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2018 and 2017, 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 2018 and 2017.

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

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 $29,048 and $124,442, respectively, for 2018 and $102,771 and $33,507, respectively, for 2017. There were no gross realized gains and losses on sales of short-term investments for 2018. The gross realized gains and losses on sales of short-term investments were $0 and $9, respectively, for 2017. The net realized (loss) gain is included in net realized capital (losses) gains less capital gains tax (benefit) in the statutory basis statements of operations. Total proceeds on the sale of long-term investments were $17,709,644 and $22,733,097 and for short-term investments were $0 and $2,276,778,150 in 2018 and 2017, respectively.

As of December 31, 2018 and 2017, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $125,032,390 and $126,213,162, respectively, are as follows:

	2018				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 42,206,761	$ 202,356	$ 115,838	$ 723,252	$ 41,570,027
State and agency municipal securities	32,405,673	65,326	57,845	388,393	32,024,761
City and county municipal securities	74,919,201	94,099	147,400	789,705	74,076,195
Corporate debt securities	82,424,779	134,886	585,441	1,030,075	80,944,149
Total bonds	$ 231,956,414	$ 496,667	$ 906,524	$2,931,425	$ 228,615,132

	2018				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 7,040,451	$ -	$ 1,469	$ 43,588	$ 6,995,394
One to five years	110,410,290	51,132	409,401	1,289,380	108,762,641
Five to ten years	71,925,709	184,159	440,138	775,509	70,894,221
Over ten years	42,579,964	261,376	55,516	822,948	41,962,876
Total bonds	$ 231,956,414	$ 496,667	$ 906,524	$2,931,425	$ 228,615,132

	2017				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 35,710,261	$ 13,506	$ 95,211	$ 299,228	$ 35,329,328
State and agency municipal securities	31,274,645	120,389	246,826	66,740	31,081,468
City and county municipal securities	77,974,429	251,860	430,246	279,432	77,516,611
Corporate debt securities	76,559,825	185,066	179,249	213,281	76,352,361
Total bonds	$ 221,519,160	$ 570,821	$ 951,532	$ 858,681	$ 220,279,768

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 $30,386,688 and fair value of $29,788,345.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2018 and 2017:

	2018					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 9,361,804	$ 115,838	$ 17,775,912	$ 723,252	$ 27,137,716	$ 839,090
State and agency municipal securites	5,670,244	57,845	20,433,253	388,393	26,103,497	446,238
City and county municipal securites	20,124,624	147,400	44,744,159	789,705	64,868,783	937,105
Corporate debt securities	34,022,101	585,441	35,092,630	1,030,075	69,114,731	1,615,516
Total bonds	$ 69,178,773	$ 906,524	$ 118,045,954	$2,931,425	$ 187,224,727	$3,837,949

	2017					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 10,195,077	$ 95,211	$ 17,418,671	$ 299,228	$ 27,613,748	$ 394,439
State and agency municipal securites	18,542,578	246,826	4,871,134	66,740	23,413,712	313,566
City and county municipal securites	32,777,480	430,246	17,332,091	279,432	50,109,571	709,678
Corporate debt securities	39,999,645	179,249	9,698,780	213,281	49,698,425	392,530
Total bonds	$ 101,514,780	$ 951,532	$ 49,320,676	$ 858,681	$ 150,835,456	$1,810,213

The unrecognized 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, 2018 and 2017, 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 an OTTI of $1,550 and $0 as of December 31, 2018 and 2017, respectively, which are included in net realized capital (losses) gains less capital gains tax (benefit) in the statutory basis statements of operations.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, 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 (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.

(2) The Company did not recognize any OTTI on loan-backed securities as of December 31, 2018 and 2017.

(3) The Company did not have any loan-backed securities with an OTTI to report by CUSIP as of December 31, 2018 or 2017.

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2018 and 2017:

	2018
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 16,767
2. 12 months or longer	768,266
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	2,669,374
2. 12 months or longer	19,563,680

	2017
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 72,543
2. 12 months or longer	350,063
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	12,735,058
2. 12 months or longer	12,966,017

(5) 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 unrecognized unrealized losses as of December 31, 2018 and 2017 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. **Low-Income Housing Tax Credits** — Not applicable.

L. Restricted Assets —

(1) Restricted assets, including pledged securities as of December 31, 2018 and 2017, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 Minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
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	1,000,000	1,000,000	-	-	1,000,000	-	-
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	$ 1,000,000	$ 1,000,000	$ -	$ -	$ 1,000,000	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 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, 2018 or 2017.

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. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2018 and 2017.

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

The Tax Cuts and Jobs Act ("Tax Reform") enacted by the U.S. federal government in December 2017 changed the existing United States tax law including reducing the U.S. corporate income tax rate from 35% in 2017 to 21% beginning in 2018. The Company accounted for the impacts of Tax Reform and as of December 31, 2017, remeasured its deferred tax assets/(liabilities) at the 21% enacted tax rate.

A. Deferred Tax Asset/Liability

(1) The components of the net deferred tax asset at December 31, 2018 and 2017, are as follows:

	2018			2017			Change		
	1	2	3	4	5	6	7	8	9
	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) Gross deferred tax assets	$ 14,966,439	$ 13	$ 14,966,452	$ 16,800,773	$ -	$ 16,800,773	$ (1,834,334)	$ 13	$ (1,834,321)
(b) Statutory valuation allowance adjustments	-	-	-	-	-	-	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	14,966,439	13	14,966,452	16,800,773	-	16,800,773	(1,834,334)	13	(1,834,321)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	14,966,439	13	14,966,452	16,800,773	-	16,800,773	(1,834,334)	13	(1,834,321)
(f) Deferred tax liabilities	373,655	1,347	375,002	7,852	1,266	9,118	365,803	81	365,884
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 14,592,784	$ (1,334)	$ 14,591,450	$ 16,792,921	$ (1,266)	$ 16,791,655	$ (2,200,137)	$ (68)	$ (2,200,205)

(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:

	2018			2017			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	$ 14,966,439	$ 13	$ 14,966,452	$ 16,800,773	$ -	$ 16,800,773	$ (1,834,334)	$ 13	$ (1,834,321)
(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)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	13,565,634	XXX	XXX	23,243,483	XXX	XXX	(9,677,849)
(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	-	-	-	-	-	-	-	-	-
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 14,966,439	$ 13	$ 14,966,452	$ 16,800,773	$ -	$ 16,800,773	$ (1,834,334)	$ 13	$ (1,834,321)

(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:

	2018	2017
(a) Ratio percentage used to determine recovery period and threshold limitation amount	255 %	319 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 135,656,343	$ 160,946,591

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2018 and 2017, is presented below:

	2018		2017		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)	$ 14,966,439	$ 13	$ 16,800,773	$ -	$ (1,834,334)	$ 13
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)	$ 14,966,439	$ 13	$ 16,800,773	$ -	$ (1,834,334)	$ 13
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, 2018 and 2017.

C. Significant Components of Income Taxes

(1) The current federal and foreign income taxes incurred for the years ended December 31, 2018 and 2017 are as follows:

	1	2	3
	2018	2017	(Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 9,072,302	$ 51,854,275	$ (42,781,973)
(b) Foreign	-	-	-
(c) Subtotal	9,072,302	51,854,275	(42,781,973)
(d) Federal income tax on net capital (losses) gains	(16,237)	31,398	(47,635)
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 9,056,065	$ 51,885,673	$ (42,829,608)

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2018 and 2017, are as follows:

	1 2018	2 2017	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 809,482	$ 357,000	$ 452,482
(2) Unearned premium reserve	7,447	4,687	2,760
(3) Policyholder reserves	9,169,650	14,043,960	(4,874,310)
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	4,978,992	2,359,922	2,619,070
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	868	35,204	(34,336)
(99) Subtotal	14,966,439	16,800,773	(1,834,334)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	14,966,439	16,800,773	(1,834,334)
(e) Capital:			
(1) Investments	-	-	-
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	13	-	13
(99) Subtotal	13	-	13
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	13	-	13
(i) Admitted deferred tax assets (2d + 2h)	14,966,452	16,800,773	(1,834,321)
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	19,851	6,731	13,120
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	353,804	1,121	352,683
(99) Subtotal	373,655	7,852	365,803
(b) Capital:			
(1) Investments	1,347	1,266	81
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	1,347	1,266	81
(c) Deferred tax liabilities (3a99 + 3b99)	375,002	9,118	365,884
4 Net deferred tax assets/liabilities (2i - 3c)	$ 14,591,450	$ 16,791,655	$ (2,200,205)

The other capital deferred tax asset of $13 for 2018 consists of unrealized loss. The other ordinary deferred tax asset of $35,204 for 2017 consists of bad debt of $34,352 and general expenses of $852. The other ordinary deferred tax liability of $353,804 for 2018 consists of discounting of unpaid loss of $352,087 and $1,717 of premium acquisition expense. The other ordinary deferred tax liability of $1,121 for 2017 consists of premium acquisition expense.

The Company's measurement of the income tax effects on Tax Reform for the year ended December 31, 2017 was reasonably estimated. The Company has completed the accounting for the income tax effects of Tax Reform by the end of the measurement period in 2018.

The Company assessed the potential realization of the gross deferred tax asset and as a result no statutory valuation allowance was required and no allowance was established as of December 31, 2018 and 2017.

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 21% in 2018 and 35% in 2017 to net (loss) income before federal income taxes incurred, plus capital gains tax/less capital gains (benefit) tax. A summarization of the significant items causing this difference as of December 31, 2018 and 2017 is as follows:

	2018		2017	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 417,699	21 %	$29,484,114	35 %
Tax-exempt interest	(291,711)	(14)	(352,599)	-
Health insurer fee	8,967,120	451	-	-
Tax effect of nonadmitted assets	(2,619,155)	(132)	(2,081,550)	(2)
Deferred corrections	4,782,330	240	-	-
Change in tax law	-	-	11,194,437	13
Total statutory income taxes	$11,256,283	566 %	$38,244,402	46 %
Federal income taxes incurred	$ 9,072,302	456 %	$51,854,275	62 %
Capital gains tax	(16,237)	(1)	31,398	-
Change in net deferred income tax	2,200,218	111	(13,641,271)	(16)
Total statutory income taxes	$11,256,283	566 %	$38,244,402	46 %

E. At December 31, 2018, the Company had no net operating loss carryforwards.

Current federal income taxes payable of $18,724,065 and $10,911,691 as of December 31, 2018 and 2017, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $1,243,692 and $34,054,463 in 2018 and 2017, respectively.

Federal income taxes incurred of $9,056,065 and $52,060,691 for 2018 and 2017, 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 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 and 2018 tax returns are under 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 2012 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.

H. **Repatriation Transition Tax** — Not applicable.

I. **Alternative Minimum Tax Credit** — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–O. Material Related Party Transactions

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.

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 per member per month ("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 expenses, and access fees under this arrangement totaled $137,570,046 and $115,629,144 in 2018 and 2017, respectively, and are included in GAE and CAE 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 following table identifies the amounts for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2018 and 2017, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25"), regardless of the effective date of the contract:

	2018	2017
United HealthCare Services, Inc.	$ 137,570,046	$ 115,629,144
Optum Rx, Inc.	88,051,257	72,625,357
United Behavioral Health	24,884,921	12,898,009
AxelaCare Intermediate Holdings, LLC	8,590,820	3,372,393
OptumInsight, Inc.	3,286,049	2,385,956

Optum Rx, Inc. provides administrative services related to pharmacy management and pharmacy claims processing for its enrollees, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products. The 2018 adoption of the Medicaid Managed Care rule provided additional insight into the classification of certain prescription drug related fees. As a result of this information, the Company reevaluated the presentation of these prescription drug related fees, and determined that it would be appropriate to include these fees as a component of general administrative expenses in 2018, whereas in 2017, the fees were included as a component of prescription drug costs.

United Behavioral Health provides mental health and substance abuse services.

AxelaCare Intermediate Holdings, LLC provides home infusion therapy services, and per diem nursing services.

OptumInsight, Inc. provides claim analytics, recovery of medical expense (benefit) 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.

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 amounts due to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company holds a $100,000,000 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 credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was renewed effective November 1, 2018. No amounts were outstanding under the line of credit as of December 31, 2018 and 2017.

The Company has a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

The Company paid dividends of $0 and $12,000,000 in 2018 and 2017, respectively, to its parent (see Note 13).

The Company has entered into reinsurance agreements with affiliated entities (see Note 23).

At December 31, 2018 and 2017, the Company reported $11,555,554 and $4,098,941, respectively, amounts due 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.

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

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, controlled, or affiliated entity.

The Company does not have any investments in a subsidiary, 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 does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2018 and 2017.

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 1,000,000 shares authorized and 900,000 shares issued and outstanding of $2 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, UHC.

(3) Payment of dividends may be restricted by the LADOI, which generally requires that dividends be paid out of unassigned surplus.

(4) The Company paid an ordinary cash dividend to UHC of $12,000,000 on December 15, 2017, which required no approval and was recorded as a reduction to unassigned 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 $45,339,570. As discussed in Note 1, in 2018 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, correction of error, net (loss) income, and dividends, represented (or reduced) by each item below is as follows:

	2018	2017	Change
Unrealized capital losses on investments	$ (62)	$ -	$ (62)
Net deferred income taxes	14,591,450	16,791,655	(2,200,205)
Nonadmitted assets	(23,709,891)	(11,237,725)	(12,472,166)
Total	$ (9,118,503)	$ 5,553,930	$ (14,672,433)

(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

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

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 made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. Those motions were argued in September 2018. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

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 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.

To date, the Company has not been selected by CMS to participate in a RADV audit.

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, 2018 and 2017, except as disclosed in Note 1 and Note 5.

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–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A. ASO Plans

On February 1, 2012, the Company began an ASO with the State of Louisiana as the Company was awarded the statewide Medicaid coordinated care network shared savings contract during 2011 (see Note 1). The Company recorded $2,345,567 in administrative fee revenues, which included the final 2014 gain share provision of $2,345,567, and related expenses for $278,525 resulting in income from operations of $2,067,042 as of December 31, 2017. These amounts are included in general administrative expenses and claims adjustment expenses in the accompanying statutory basis statements of operations. Effective February 1, 2015, the Company's ASO Contract converted into the Medicaid fully insured business.

The Company does not have any net gain from operations of the uninsured portion of ASO uninsured plans and the uninsured portion of partially insured plans in 2018. The net gain from operations of the uninsured portion of ASO uninsured plans and the uninsured portion of partially insured plans for 2017 follows:

	2017		
	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
a. Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$2,067,042	$ -	$2,067,042
b. Total net other income or expenses (including interest paid to or received from plans)	-	-	-
c. Net gain (loss) from operations	2,067,042	-	2,067,042
d. Total claim payment volume	-	-	-

B. The Company has no operations from Administrative Services Contracts.

C. The Medicare Part D program is a partially insured plan. The Company recorded a receivable in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus of $260,743 at December 31, 2018, 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 $13,297 and also a payable of $24,205 at December 31, 2018, 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*.

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 2018 and 2017.

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.

The estimated fair values of bonds, short-term investments and cash equivalents 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 present information about the Company's financial assets that are measured and reported at fair value at December 31, 2018, 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. The Company does not have financial assets measured and reported at fair value at December 31, 2017:

		December 31, 2018				
Description for Each Class of Asset or Liability		(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Total
a. Assets at fair value:						
Perpetual preferred stock:						
Industrial and misc	(a)	$ -	$ -	$ -	$ -	$ -
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		-	-	-	-	-
Parent, subsidiaries, and affiliates		-	-	-	-	-
Total common stock		-	-	-	-	-
Derivative assets:						
Interest rate contracts		-	-	-	-	-
Foreign exchange contracts		-	-	-	-	-
Credit contracts		-	-	-	-	-
Commodity futures contracts		-	-	-	-	-
Commodity forward contracts		-	-	-	-	-
Total derivatives		-	-	-	-	-
Money-market funds		123,843,352	-	-	-	123,843,352
Separate account assets		-	-	-	-	-
Total assets at fair value/NAV		$123,843,352	$ -	$ -	$ -	$123,843,352
b. Liabilities at fair value:						
Derivative liabilities		$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value		$ -	$ -	$ -	$ -	$ -

(a) $0 transferred from Level 1 to Level 2 as an alternative method was utilized to determine fair value as active market price was not readily available.

There were no transfers between Levels 1 and 2 during the year ended December 31, 2018.

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(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 year ended December 31, 2018.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(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, 2018 and 2017 is presented in the table below:

	2018						
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 41,570,027	$ 42,206,761	$ 13,413,831	$ 28,156,196	$ -	$ -	$ -
State and agency municipal securities	32,024,761	32,405,673	-	32,024,761	-	-	-
City and county municipal securities	74,076,195	74,919,201	-	74,076,195	-	-	-
Corporate debt securities	80,944,149	82,424,779	-	80,944,149	-	-	-
Cash equivalents	123,843,352	123,843,352	123,843,352	-	-	-	-
Total bonds and cash equivalents	$ 352,458,484	$ 355,799,766	$ 137,257,183	$ 215,201,301	$ -	$ -	$ -

	2017						
Types of Financial Investment	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 35,329,328	$ 35,710,261	$ 17,496,037	$ 17,833,291	$ -	$ -	$ -
State and agency municipal securities	31,081,468	31,274,645	-	31,081,468	-	-	-
City and county municipal securities	77,516,611	77,974,429	-	77,516,611	-	-	-
Corporate debt securities	76,352,361	76,559,825	-	76,352,361	-	-	-
Total bonds	$ 220,279,768	$ 221,519,160	$ 17,496,037	$ 202,783,731	$ -	$ -	$ -

Included as Level 1 in U.S. government and agency securities in the fair value hierarchy tables above are U.S. Treasury securities of $13,413,831 and $17,496,037 as of December 31, 2018 and December 31, 2017, respectively.

There are no commercial paper investments included in corporate debt securities in the fair value hierarchy tables above as of December 31, 2018 and 2017.

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — 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, 2018 and 2017.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2018 and 2017.

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 2018 and 2017.

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.

(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, 2018, the Company is not aware of any possible proceeds of insurance-linked securities.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through May 3, 2019, which is the date these statutory basis financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

In April 2019, the Company performed a review of the estimated premium deficiency reserve recorded at December 31, 2018. The updated analysis resulted in a $43,665,000 premium deficiency reserve required as of December 31, 2018. This is an increase of $22,809,000 over the premium deficiency reserve originally recorded at December 31, 2018 of $20,856,000. The adjustment as a result of this change in estimate of the premium deficiency reserve was recorded in the 2018 statutory basis financial statements (see Notes 30 and 32).

There are no other events subsequent to December 31, 2018, 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. The 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. Pursuant to the 2019 HIF moratorium (see Note 1), no HIF will be payable in 2019 and therefore there is no amount apportioned out of unassigned funds in 2018 representing an estimate of the 2019 HIF.

The table below presents information regarding the annual fee under Section 9010 of the ACA as of December 31, 2018 and 2017:

		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	$ -	$	45,339,570
C.	ACA fee assessment paid	42,700,576		-
D.	Premium written subject to ACA 9010 assessment	-		2,128,252,188
E.	Total Adjusted Capital before surplus adjustment	150,247,793		
F.	Total Adjusted Capital after surplus adjustment	150,247,793		
G.	Authorized Control Level (Five-Year Historical Line 15)	62,082,161		
H.	Would reporting the ACA assessment as of December 31, 2018, have triggered an RBC action level (Yes/No)?	No		

There are no other events subsequent to December 31, 2018 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 and other nonaffiliated reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company has an insolvency-only reinsurance agreement with UHIC, an affiliate of the Company, to provide insolvency protection for its enrollees. Reinsurance premiums, which are calculated on a percentage of member premium income, of $1,889,471 and $1,806,266 in 2018 and 2017, respectively, are netted against net premium income in the statutory basis statements of operations.

The Company entered into a reinsurance agreement with an affiliated entity, Unimerica Insurance Company, Inc. to cede obligations relating to Louisiana enrollees relating to mental health and substance use disorder benefits and chiropractic, physical and occupational therapy treatments benefits. The agreement has been approved by the LADOI. Reinsurance premiums, which are calculated on a PMPM basis, of $570,867 and $122,996,803 as of December 31, 2018 and 2017, respectively were netted against net premium income in the statutory basis statements of operations. Reinsurance recoveries of ($6,663,928) and $151,574,468 as of December 31, 2018 and 2017, respectively are

included in net reinsurance recoveries in the statutory basis statements of operations. There were $225,986 and $22,942,878 of amounts recoverable from reinsurers related to this agreement as of December 31, 2018 and 2017, respectively. 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 reinsurance agreement was terminated effective December 31, 2017.

Pursuant to Section 1341 of the ACA, through 2017, the Company was subject to the reinsurance provision for compliant individual policies (see Note 24).

The effect of internal and external reinsurance agreements outlined above on net premium income and hospital and medical expenses is presented below:

	2018	2017
Premiums:		
Direct	$ 2,257,443,108	$ 2,106,415,899
Ceded:		
Affiliate	2,460,337	124,803,069
Net premium income	$ 2,254,982,771	$ 1,981,612,830
Hospital and medical expenses:		
Direct	$ 1,889,217,023	$ 1,764,075,554
Ceded:		
Affiliate	6,663,928	(155,212,154)
Net hospital and medical expenses	$ 1,895,880,951	$ 1,608,863,400

The Company recognized reinsurance recoveries related to internal and external reinsurance agreements of $(6,663,928) and $155,212,154 in 2018 and 2017, respectively, which are recorded as net reinsurance recoveries in the statutory basis statements of operations. In addition, reinsurance recoverables related to internal and external reinsurance agreements of $271,846 and $24,539,372 for paid losses are recorded as amounts recoverable from reinsurers and $227,522 and $19,984,188 for unpaid losses are recorded as a reduction to claims unpaid in 2018 and 2017, 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 ( ) No (X)

(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, 2018.

(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 2018 and 2017, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2018 or 2017.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — 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 (from) the Company are recorded in premiums and considerations and aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in unearned premium reserves and reserve for rate credits 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 $47,082,203 and $54,171,433, representing 2.2% and 2.6% of total direct premiums written as of December 31, 2018 and 2017, 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 $5,085,865, representing 0.2% of total direct premiums written as of December 31, 2018.

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 $370,152 representing, less than 0.1% of total direct premiums written for 2018.

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 $5,085,865 representing, 0.2% of total direct premiums written for 2018.

CMS has released the final Medicaid Managed Care Rule which is subject to each State's administration elections. This rule is the first major update to the Medicaid Managed Care regulations in more than a decade. Many items including a minimum loss ratio requirement were implemented for contracts with an effective date starting on or after July 1, 2017 while other elements of the regulation will be implemented over the following decade. Pursuant to the regulations, for contracts effective on or after July 1, 2017 premiums associated with the Company's Medicaid line of business is subject to retrospectively rated features based on the actual medical loss ratios experienced on this product. The calculation is pursuant to the Medicaid Managed Care guidance. The total amount of direct premiums written for the Medicaid line of business for which a portion is subject to the retrospectively rated features was $1,858,897,429 and $1,748,913,125, representing 82.3% and 83.0% of total direct premiums written as of December 31, 2018 and December 31, 2017, respectively.

The Medicaid contract with the State of Louisiana has a redetermination feature for which a portion of total direct premiums written is at risk and can be returned to the Company based on various utilization measures. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the redetermination feature was $1,858,897,429 and $1,748,913,125, representing 82.3% and 83.0% of the Company's total direct premiums written as of December 31, 2018 and 2017, respectively.

The Medicaid contract with the State of Louisiana includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the redetermination feature was $1,858,897,429 and $1,748,913,125, representing 82.3% and 83.0%, of the Company's total direct premiums written, as of December 31, 2018 and 2017, respectively.

The Medicaid contract with the State of Louisiana includes a retrospectively rated feature related to the Value Added Benefits and Services program. The Company has estimated accrued retrospective premiums pursuant to the contract. The total amount of direct premiums written

subject to the retrospectively rated feature was $1,858,897,429 and $1,748,913,125, representing 82.3% and 83.0% of the Company's total direct premiums written as of December 31, 2018 and 2017, respectively.

D. The Company is required to maintain specific minimum loss ratios on the comprehensive commercial and Medicare lines of business. The Company's actual loss ratios on the comprehensive commercial and Medicare lines of business were in excess of the minimum requirements and as a result, no minimum medical loss ratio rebate liability was required to be established at December 31, 2018 and 2017.

Pursuant to the Medicaid Managed Care Rule and/or state contractual minimum loss ratio requirements, the Company is required to maintain specific minimum loss ratios on its Healthy Louisiana and Healthy Louisiana populations. The Company has estimated $35,664,587 and $26,752,770 in estimated Medicaid Managed Care Rule and/or state minimum loss ratio rebates on its Healthy Louisiana population as of December 31, 2018 and December 31, 2017, respectively.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2018 and 2017 subject to the risk-sharing provisions of the ACA.

The ACA imposed 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 corridors.

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. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. The operation of the high-cost risk pools exclude a percentage of costs above a threshold level determined by federal regulations. The program operates two national high-cost risk pools, one for individuals and one for small groups. 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:

		December 31, 2018
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high risk pool payments)	$ 15,547
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	587
3.	Premium adjustments payable due to ACA Risk Adjustment (including high risk pool payments)	163,200
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	140,596
5.	Reported in expenses as ACA risk adjustment user fees (incurred/paid)	601
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ 45,860
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	-
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)	-
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(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	
	1	2	3	4	Prior Year Accrued Less Payments (Col 1 - 3) 5	Prior Year Accrued Less Payments (Col 2 - 4) 6	To Prior Year Balances 7	To Prior Year Balances 8		Cumulative Balance from Prior Years (Col 1 - 3 + 7) 9	Cumulative Balance from Prior Years (Col 2 - 4 + 8) 10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium Adjustment Receivable (including high risk pool payments)	$ 380,126	$ -	$ 662,797	$ -	$ (282,671)	$ -	$ 298,219	$ -	A	$ 15,548	$ -
2. Premium Adjustment (Payable) (including high risk pool premium)	-	(5,577)	-	-	-	(5,577)	-	5,577	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	380,126	(5,577)	662,797	-	(282,671)	(5,577)	298,219	5,577		15,548	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	1,596,494	-	1,550,633	-	45,861	-	-	-	C	45,861	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	1,596,494	-	1,550,633	-	45,861	-	-	-		45,861	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ 1,976,620	$ (5,577)	$ 2,213,430	$ -	$ (236,810)	$ (5,577)	$ 298,219	$ 5,577		$ 61,409	$ -

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2018 was adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year. The risk adjustment receivable as of December 31, 2017 utilized paid claims through October 31, 2017. The adjustment to the prior year receivable balance reflects the true up to final results for the 2017 Benefit Year.

B. The risk adjustment payable as of December 31, 2018 was adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year. The risk adjustment payable as of December 31, 2017 utilized paid claims through October 31, 2017. The adjustment to the prior year payable balance reflects the true up to final results for the 2017 Benefit Year.

C. N/A

D. N/A

E. N/A

F. N/A

G. N/A

H. N/A

I. N/A

J. N/A

(4) The Company does not have any risk corridor receivables or payables to present in the table below.

Risk Corridors Program Year	Accrued during the Prior Year on Business Written before December 31 of the Prior Year 1 Receivable	2 (Payable)	Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year 3 Receivable	4 (Payable)	Differences 5 Prior Year Accrued Less Payments (Col 1 - 3) Receivable	6 Prior Year Accrued Less Payments (Col 2 - 4) (Payable)	Adjustments 7 To Prior Year Balances Receivable	8 To Prior Year Balances (Payable)	Ref	Unsettled Balances as of the Reporting Date 9 Cumulative Balance from Prior Years (Col 1 - 3 + 7) Receivable	10 Cumulative Balance from Prior Years (Col 2 - 4 + 8) (Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	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	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A.
B.
C.
D.
E.
F.

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-admissions) (1 - 2 - 3)	5 Non-admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	4,251,826	4,251,826	-	-	-	-
c. 2016	209,226	209,226	-	-	-	-
d. Total (a + b + c)	$ 4,461,052	$ 4,461,052	$ -	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables and reinsurance recoverables for the years ended December 31, 2018 and 2017:

	2018		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$(234,053,825)	$ (234,053,825)
Paid claims — net of health care receivables and reinsurance recoveries collected	1,711,424,208	156,138,681	1,867,562,889
End of year claim reserve	237,606,753	11,996,790	249,603,543
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	1,949,030,961	(65,918,354)	1,883,112,607
Beginning of year health care receivables and reinsurance recoverables	-	46,372,083	46,372,083
End of year health care receivables and reinsurance recoverables	(11,769,211)	(21,834,528)	(33,603,739)
Total incurred claims	$1,937,261,750	$ (41,380,799)	$1,895,880,951

	2017		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (195,042,056)	$ (195,042,056)
Paid claims — net of health care receivables and reinsurance recoveries collected	1,451,650,886	131,005,042	1,582,655,928
End of year claim reserve	206,558,629	27,495,196	234,053,825
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	1,658,209,515	(36,541,818)	1,621,667,697
Beginning of year health care receivables and reinsurance recoverables	-	33,567,786	33,567,786
End of year health care receivables and reinsurance recoverables	(35,185,148)	(11,186,935)	(46,372,083)
Total incurred claims	$ 1,623,024,367	$ (14,160,967)	$1,608,863,400

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care and other amounts receivables and reinsurance recoverables as of December 31, 2017 was $187,681,742. As of December 31, 2018, $156,138,681 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables and reinsurance recoverables are now $(9,837,738) as a result of re-estimation of unpaid claims. Therefore, there has been $41,380,799 favorable prior year development since December 31, 2017 to December 31, 2018. The primary drivers consist of favorable development as a result of a change in the provider gain share provisions of $29,244,163, favorable development of $17,965,966 in retroactivity for inpatient, outpatient, physician, and pharmacy claims and favorable development of $5,871,255 as a result of a change in the provision for adverse deviations in experience, offset by unfavorable development of $11,555,552 in behavioral and other health reserves.

At December 31, 2017, the Company recorded $14,160,967 of favorable development related to favorable development as a result of a change in the provision for adverse deviations in experience of $6,890,139 and favorable development of $9,513,645 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, offset by unfavorable development of $2,004,398 as a result of the provider gain share provisions (See Note 18).

The Company incurred CAE of $88,909,905 and $75,489,675 in 2018 and 2017, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2018 and 2017:

	2018	2017
Total claims adjustment expenses	$ 88,909,905	$ 75,489,675
Less: current year unpaid claims adjustment expenses	(1,351,967)	(1,370,586)
Add: prior year unpaid claims adjustment expenses	1,370,586	1,848,701
Total claims adjustment expenses paid	$ 88,928,524	$ 75,967,790

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2018.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2018 or 2017.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2018 or 2017.

28. HEALTH CARE RECEIVABLES

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
12/31/2018	$ 7,084,291	$ -	$ -	$ -	$ -
9/30/2018	6,505,071	6,266,979	3,477,796	-	-
6/30/2018	6,775,195	6,687,387	3,798,374	2,248,972	-
3/31/2018	6,788,436	6,497,349	3,031,387	2,776,322	292,025
12/31/2017	6,505,624	6,487,346	3,462,157	2,780,480	224,248
9/30/2017	6,070,663	5,757,948	2,392,970	2,847,846	485,034
6/30/2017	6,470,423	5,681,960	997,521	3,952,323	707,832
3/31/2017	6,412,539	5,854,666	553,351	4,057,423	1,202,798
12/31/2016	8,240,848	8,143,420	2,595,910	3,889,110	1,502,686
9/30/2016	8,096,235	7,950,174	2,536,891	3,928,911	1,359,109
6/30/2016	7,554,604	7,636,689	4,650,049	2,571,933	358,262
3/31/2016	6,622,929	6,499,072	1,321,909	4,918,589	254,789

Of the amount reported as health care receivables, $9,878,575 and $10,028,816 relates to pharmacy rebates receivable as of December 31, 2018 and 2017, respectively. This decrease is primarily due to the change in generic/name brand mix.

B. The Company does not have any risk-sharing receivables.

The Company has admitted claim overpayments of $258,655 and $575,145 in 2018 and 2017, respectively, which are included in health care receivables in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2018 or 2017.

30. PREMIUM DEFICIENCY RESERVES

The following table summarizes the Company's premium deficiency reserves as of December 31, 2018 and 2017:

	2018
1. Liability carried for premium deficiency reserves	$ 43,665,000
2. Date of the most recent evaluation of this liability	12/31/2018
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2017
1. Liability carried for premium deficiency reserves	$ 66,876,000
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 [ ]

Premium deficiency reserves are included in aggregate health policy reserves (see Note 1 — *Basis of Presentation*) in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2018 and 2017, 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 claims unpaid and aggregate health claim reserves.

32. RECONCILIATION TO THE ANNUAL STATEMENT

During 2018, the Company determined that it had overstated the premium deficiency reserves for the year ended December 31, 2017. In 2018, the Company reflected this change as a correction of error in the statutory basis statements of changes in capital and surplus (see Note 2). During the audits of the 2018 and 2017 statutory basis financial statements, necessary adjustments were discovered during the subsequent event review related to changes in the premium deficiency reserves from what was previously filed by the Company with the LADOI. The below adjustments for 2018 were the result of a change in estimate based on new information received subsequent to the 2018 Annual Statement submission on March 1, 2019, correction of error, and the 2017 adjustments that were reported in the 2018 Annual Statement field by the Company with the LADOI.

The following table reconciles the 2018 Annual Statement previously filed to the 2018 statutory basis financial statements:

	Per Audited Statutory Basis Financial Statements	Per Annual Statement	Variance
Assets	$ 566,939,918	$ 562,150,028	$ 4,789,890
Liabilities	416,692,125	393,883,125	22,809,000
Capital and surplus	150,247,793	168,266,903	(18,019,110)
Expenses	2,256,655,453	2,253,197,453	3,458,000
Net loss	(7,067,021)	(3,609,021)	(3,458,000)

The following table is also provided for additional information regarding the impact of the adjustments to capital and surplus:

Capital and surplus per annual statement	$ 168,266,903
Adjustment to change in net deferred income tax	4,789,890
Adjustment to decrease in reserves for accident and health contracts	(22,809,000)
Capital and surplus per statutory basis financial statements	$ 150,247,793

The following table is also provided for additional information regarding the impact of the adjustments to 2018 net income:

Net loss per annual statement	$ (3,609,021)
Adjustment to decrease in reserves for accident and health contracts	(3,458,000)
Net income per statutory basis financial statements	$ (7,067,021)

The result of the adjustments made to the 2018 statutory basis financial statements is a net decrease in total capital and surplus of $18,019,110 and a decrease in net income of $3,458,000.

During the audit of the 2017 statutory basis financial statements, necessary adjustments were discovered during the subsequent event review related to changes in the premium deficiency reserves and net premium income from what was previously filed by the Company with the LADOI. The following tables reconcile the 2017 Annual Statement as previously filed to the 2017 audited statutory basis financial statements:

	Per Audited Statutory Basis Financial Statements	Per Annual Statement	Variance
Assets	$ 556,237,623	$ 550,247,583	$ 5,990,040
Liabilities	407,023,376	378,499,376	28,524,000
Capital and surplus	149,214,247	171,748,207	(22,533,960)
Revenues	2,006,757,143	1,998,566,171	8,190,972
Expenses	1,924,591,896	1,896,067,896	28,524,000
Federal income tax expense	51,854,275	48,987,435	2,866,840
Net income	32,354,653	55,554,521	(23,199,868)

The following table is also provided for additional information regarding the impact of the adjustments to capital and surplus:

Capital and surplus per annual statement	$ 171,748,207
Adjustment to change in net deferred income tax	5,990,040
Adjustment to increase in reserves for accident and health contracts	(28,524,000)
Capital and surplus per statutory basis financial statements	$ 149,214,247

The following table is also provided for additional information regarding the impact of the adjustments to net income:

Net income per annual statement	$ 55,554,521
Adjustment to net premium income	8,190,972
Adjustment to increase in reserves for accident ahd health contracts	(28,524,000)
Adjustment to federal income taxes incurred	(2,866,840)
Net income per statutory basis financial statements	$ 32,354,653

The result of the adjustments made to the 2017 statutory basis financial statements is a net decrease in total capital and surplus of $22,533,960 and a decrease in net income of $23,199,868.

* * * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2018
(To Be Filed by April 1)

Of The UnitedHealthcare of Louisiana, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 95833 Federal Employer's Identification Number (FEIN) 72-1074008

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. $ 566,939,918

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	Goldman Sachs - FGTXX	Bonds	$ 20,053,846	3.5 %
2.02	DEUTSCHE GOV - ICAXX	Bonds	$ 20,032,696	3.5 %
2.03	FNMA	Bonds	$ 11,547,486	2.0 %
2.04	JP Morgan - OGVXX	Bonds	$ 10,033,197	1.8 %
2.05	FHLMC	Bonds	$ 8,700,232	1.5 %
2.06	HSBC - HGIXX	Bonds	$ 8,304,569	1.5 %
2.07	Morgan Stanley Institutional - MVRXX	Bonds	$ 5,052,999	0.9 %
2.08	TUGXX US Equity - TUGXX	Bonds	$ 5,041,957	0.9 %
2.09	DEUTSCHE INV MGT - DBBXX	Bonds	$ 5,018,810	0.9 %
2.10	NEW YORK ST URBA - ITR	Bonds	$ 3,545,188	0.6 %

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	$ 201,692,910	35.6 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 30,263,504	5.3 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	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 [X] No [ ]

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	$ 0	0.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	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:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	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			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

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 [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	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

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1. Bonds:						
1.1 U.S. treasury securities	13,544,280	3.794	13,544,280	0	13,544,280	3.794
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.000	0	0	0	0.000
1.22 Issued by U.S. government sponsored agencies	0	0.000	0	0	0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	0	0.000	0	0	0	0.000
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	13,888,625	3.890	13,888,625	0	13,888,625	3.890
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	39,810,308	11.152	39,810,308	0	39,810,308	11.152
1.43 Revenue and assessment obligations	52,646,461	14.747	52,646,461	0	52,646,461	14.747
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	8,414,762	2.357	8,414,762	0	8,414,762	2.357
1.512 Issued or guaranteed by FNMA and FHLMC	20,247,718	5.672	20,247,718	0	20,247,718	5.672
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	0	0.000	0	0	0	0.000
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	1,724,208	0.483	1,724,208	0	1,724,208	0.483
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)	81,680,052	22.880	81,680,052	0	81,680,052	22.880
2.2 Unaffiliated non-U.S. securities (including Canada)	0	0.000	0	0	0	0.000
2.3 Affiliated securities	0	0.000	0	0	0	0.000
3. Equity interests:						
3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
3.2 Preferred stocks:						
3.21 Affiliated	0	0.000	0	0	0	0.000
3.22 Unaffiliated	0	0.000	0	0	0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.000	0	0	0	0.000
3.32 Unaffiliated	0	0.000	0	0	0	0.000
3.4 Other equity securities:						
3.41 Affiliated	0	0.000	0	0	0	0.000
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	0	0.000	0	0	0	0.000
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	0	0.000	0	0	0	0.000
9. Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	125,032,390	35.024	125,032,390	0	125,032,390	35.024
11. Other invested assets	0	0.000	0	0	0	0.000
12. Total invested assets	356,988,804	100.000	356,988,804	0	356,988,804	100.000

OTHER ATTACHMENT

Deloitte.

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To the Audit Committee of
UnitedHealthcare of Louisiana, Inc.
3838 North Causeway Boulevard, Suite 2600
Metairie, LA 70002

The Management of
UnitedHealthcare of Louisiana, Inc.
3838 North Causeway Boulevard, Suite 2600
Metairie, LA 70002

Dear Members of the 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 of Louisiana, Inc. (the "Company") for the years ended December 31, 2018, and 2017, and have issued our report thereon dated May 3, 2019. 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 Louisiana Department of Insurance, 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 14 years and 11 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 29 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 Louisiana Department of Insurance 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 Louisiana Department of Insurance. 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 Louisiana Department of Insurance.

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 (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Louisiana Department of Insurance has filed a Report of Examination covering 2018, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Louisiana Department of Insurance or its delegates, at the offices of the insurer, at our offices, at the Louisiana Department of Insurance, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Louisiana Department of Insurance, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Louisiana Department of Insurance. In addition, to the extent requested, we may provide the Louisiana Department of Insurance with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Louisiana Department of Insurance or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Louisiana Department of Insurance; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

e. The engagement partner has served in this capacity with respect to the Company since 2018, 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 of Louisiana, Inc. and for filing with the Louisiana Department of Insurance 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 3, 2019

UnitedHealthcare of Louisiana, Inc.

Statutory Basis Financial Statements as of and
for the Years Ended December 31, 2019 and 2018,
Supplemental Schedules as of and for the
Year Ended December 31, 2019,
Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE OF LOUISIANA, INC.

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INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of Louisiana, Inc.
3838 North Causeway Boulevard, Suite 2600
Metairie, LA 70002

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of Louisiana, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2019 and 2018, 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 Louisiana Department of Insurance. 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 audit 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 of Louisiana, Inc. as of December 31, 2019 and 2018, 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 Louisiana Department of Insurance 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 of Louisiana, Inc. using accounting practices prescribed or permitted by the Louisiana Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Louisiana Department of Insurance. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2019 audit was conducted for the purpose of forming an opinion on the 2019 statutory basis financial statements as a whole. The supplemental schedule of investment risks interrogatories and the supplemental summary investment schedule, as of and for the year ended December 31, 2019 are presented for the purpose of additional analysis and are not a required part of the 2019 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 2019 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 2019 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 of Louisiana, Inc. 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

April 27, 2020

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2019 AND 2018

	2019	2018
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 234,814,073	$ 231,956,414
Cash of $45,057 and $1,189,038, and cash equivalents of $177,592,989 and $123,843,352 in 2019 and 2018, respectively	177,638,046	125,032,390
Subtotal cash and invested assets	412,452,119	356,988,804
OTHER ASSETS:		
Investment income due and accrued	2,304,540	2,323,291
Premiums and considerations	195,005,855	182,353,026
Amounts recoverable from reinsurers	-	271,846
Amounts receivable relating to uninsured plans	217,734	274,040
Net deferred tax asset	13,293,810	14,591,450
Health care receivables	2,814,050	10,137,230
Other assets	-	231
Subtotal other assets	213,635,989	209,951,114
TOTAL ADMITTED ASSETS	$ 626,088,108	$ 566,939,918
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 305,410,683	$ 242,105,849
Accrued medical incentive pool and bonus amounts	10,916,024	4,909,576
Unpaid claims adjustment expenses	1,111,430	1,351,967
Aggregate health policy reserves	59,629,719	79,492,787
Aggregate health claim reserves	2,544,795	2,588,118
Premiums received in advance	141,813	177,316
General expenses due or accrued	45,408,243	55,596,719
Current federal income taxes payable	4,258,754	18,724,065
Ceded reinsurance premiums payable	162,450	165,808
Remittances and items not allocated	438	161
Amounts due to parent, subsidiaries, and affiliates, net	11,436,936	11,555,554
Liability for amounts held under uninsured plans	52,913	24,205
Total liabilities	441,074,198	416,692,125
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	43,016,618	-
Common capital stock, $2 par value —1,000,000 shares authorized; 900,000 shares issued and outstanding	1,800,000	1,800,000
Gross paid-in and contributed surplus	67,138,440	67,138,440
Unassigned surplus	73,058,852	81,309,353
Total capital and surplus	185,013,910	150,247,793
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 626,088,108	$ 566,939,918

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
REVENUES:		
Net premium income	$ 2,342,968,696	$ 2,254,982,771
Change in reserve for rate credits	4,385,743	(2,696,722)
Total revenues	2,347,354,439	2,252,286,049
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	1,193,708,752	1,204,185,537
Other professional services	22,498,626	23,131,909
Prescription drugs	411,228,861	331,057,520
Full Medicaid pricing pass through	369,529,001	346,377,610
Incentive pool, withhold adjustments, and bonus amounts	15,978,309	(15,535,553)
Net reinsurance payments	657,055	6,663,928
Total hospital and medical	2,013,600,604	1,895,880,951
Claims adjustment expenses	95,129,543	88,909,905
General administrative expenses	210,859,871	272,302,597
Decrease in reserves for accident and health contracts	(20,432,000)	(438,000)
Total underwriting deductions	2,299,158,018	2,256,655,453
NET UNDERWRITING GAIN (LOSS)	48,196,421	(4,369,404)
NET INVESTMENT GAINS:		
Net investment income earned	8,516,496	6,835,785
Net realized capital losses less capital benefit of $15,440 and $16,327 in 2019 and 2018, respectively	(100,047)	(80,370)
Total net investment gains	8,416,449	6,755,415
NET LOSS FROM AGENTS' OR PREMIUM BALANCES CHARGED OFF	(63,492)	(85,730)
OTHER LOSSES	-	(295,000)
NET INCOME BEFORE FEDERAL INCOME TAXES	56,549,378	2,005,281
FEDERAL INCOME TAXES INCURRED	7,633,194	9,072,302
NET INCOME (LOSS)	$ 48,916,184	$ (7,067,021)

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2019 AND 2018

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
		Shares	Amount			
BALANCE — January 1, 2018	$ 45,339,570	900,000	$ 1,800,000	$ 67,138,440	$ 34,936,237	$ 149,214,247
Net loss	-	-	-	-	(7,067,021)	(7,067,021)
Change in net unrealized capital losses on investments less capital gains benefit of ($13)	-	-	-	-	(49)	(49)
Change in net deferred income taxes	-	-	-	-	(2,200,218)	(2,200,218)
Change in nonadmitted assets	-	-	-	-	(12,472,166)	(12,472,166)
Correction of error (Note 2)	-	-	-	-	22,773,000	22,773,000
Section 9010 ACA subsequent fee year assessment	(45,339,570)	-	-	-	45,339,570	-
BALANCE — December 31, 2018	-	900,000	1,800,000	67,138,440	81,309,353	150,247,793
Net income	-	-	-	-	48,916,184	48,916,184
Change in net unrealized capital losses on investments less capital gains benefit of ($71)	-	-	-	-	267	267
Change in net deferred income taxes	-	-	-	-	(1,297,569)	(1,297,569)
Change in nonadmitted assets	-	-	-	-	(12,852,765)	(12,852,765)
Section 9010 ACA subsequent fee year assessment	43,016,618	-	-	-	(43,016,618)	-
BALANCE — December 31, 2019	$ 43,016,618	900,000	$ 1,800,000	$ 67,138,440	$ 73,058,852	$ 185,013,910

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 2,335,729,020	$ 2,217,018,781
Net investment income	10,640,897	9,342,955
Benefit and loss related payments	(1,950,089,443)	(1,867,562,889)
Operating expenses paid	(316,401,361)	(352,744,638)
Federal income taxes paid, net	(22,083,065)	(1,243,692)
Net cash provided by operations	57,796,048	4,810,517
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments:		
Bonds sold or matured	77,009,943	36,430,685
Miscellaneous proceeds	338	275
Total investment proceeds	77,010,281	36,430,960
Cost of investments acquired:		
Bonds	(82,083,644)	(49,879,025)
Total cost of investments acquired	(82,083,644)	(49,879,025)
Net cash used in investments	(5,073,363)	(13,448,065)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash (applied) provided through net transfers (to) from affiliates	(118,618)	7,456,613
Other cash provided	1,589	163
Net cash (used in) provided by financing and miscellaneous activities	(117,029)	7,456,776
RECONCILIATION OF CASH AND CASH EQUIVALENTS:		
NET CHANGE IN CASH AND CASH EQUIVALENTS	52,605,656	(1,180,772)
CASH AND CASH EQUIVALENTS — Beginning of year	125,032,390	126,213,162
CASH AND CASH EQUIVALENTS — End of year	$ 177,638,046	$ 125,032,390

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of Louisiana, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of 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 April 9, 1986, as an HMO and operations commenced in November 1986. The Company is certified as an HMO, by the Louisiana Department of Insurance ("LADOI").The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees.

The Company offers comprehensive commercial products to individual and employer groups. Each contract outlines the coverage provided and renewal provisions.

Effective January 2018, the Company serves as a plan sponsor offering Medicare Parts A & B, along with Medicare Part D prescription drug insurance coverage (collectively "Medicare program") under a contract with the Centers for Medicare and Medicaid Services ("CMS"). The Company receives seven different payment elements either during the year or at final settlement in the subsequent year: 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"). The applicable payment elements are received either during the year or at the settlement in the subsequent year. Each component of the Medicare program is further defined throughout Note 1.

The Company has a contract with the State of Louisiana, Louisiana Department of Health ("LDH"), to provide health care services to Healthy Louisiana (a program for uninsured adults) eligible beneficiaries in Louisiana. The current contract is effective through December 31, 2020.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the LADOI.

The LADOI recognizes only statutory accounting practices, prescribed or permitted by the State of Louisiana, for determining and reporting the financial condition and results of operations of an HMO for determining its solvency under Louisiana 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 or permitted by the State of Louisiana and the NAIC SAP which materially affect the statutory basis net income (loss) and capital and surplus, as illustrated in the table below:

Net Income (Loss)	SSAP #	AFS Line	December 31, 2019	December 31, 2018
(1) Company state basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	$ 48,916,184	$ (7,067,021)
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 48,916,184	$ (7,067,021)
Capital and Surplus				
(5) Company state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	$ 185,013,910	$ 150,247,793
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 185,013,910	$ 150,247,793

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 hospital and medical benefits, claims unpaid, aggregate health policy reserves (including medical loss ratio rebates and premium deficiency reserves ("PDR")) and aggregate health claim reserves, 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 (loss) 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 or permitted by the LADOI. 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 are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Securities Valuation Office of the NAIC ("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 are valued and reported using market prices published by the SVO in accordance with the NAIC Valuation of Securities manual prepared by the SVO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(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 holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) PDR (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 health policy reserves 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 data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected as a decrease in reserves for life and accident and health contracts 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 PDR 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. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the statutory basis statements of operations. 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 unpaid CAE 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, 2019 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) The Company does not carry any fixed assets on the statutory basis financial statements;

(13) Health care receivables 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 receivables 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 receivables 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;

- Cash and cash equivalents 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 and cash equivalents includes cash balances and investments that will mature in one year or less from the balance sheet date;

- The Company has no short-term investments;

- Cash represents cash held by the Company in operating accounts. Claims and other payments are made from the operating accounts daily;

- 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. 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 ("NAV") as a practical expedient;

- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital losses less capital gains benefit in the statutory basis statements of operations;

- 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 losses less capital gains benefit 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 an other-than-temporary impairment ("OTTI") of $0 and $1,550 for the years ended December 31, 2019 and 2018, respectively.

- The NAIC SAP requires the following captions to be taken into consideration in the reconciliation of the statutory basis statements of cash flows: cash, including cash overdrafts, cash equivalents, and short-term investments, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, pursuant to Accounting Standards Update 2016-18, *Statement of Cash Flows, Restricted Cash*, the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash 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 NAIC SAP. The statutory basis statements of cash flows are prepared in accordance with the NAIC Annual Statement Instructions.

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 groups, CMS, state Medicaid agencies and 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 (see Note 24):

a) risk adjustment receivables as defined in Section 1343 of the Affordable Care Act ("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. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. 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 corridor receivables for which adjustments are based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare program plan varies more than 5% above the level estimated in the original bid submitted by the Company and approved by CMS;

c) CMS risk adjustment receivables. The risk adjustment model apportions premiums paid to all health 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;

d) Premium withhold receivables for a Medicaid performance guarantees. The pay for performance program is based upon the Company's performance against various quality and operational measures established in the Company's contract with the State which is based on a stated percentage of total direct premiums written. Premium adjustments for the Medicaid performance guarantee program are accounted for as premium adjustments subject to redetermination; and

e) Hepatitis C risk corridor receivables for a Medicaid program for which adjustments are based on plan variances from the original estimated capitation rates.

Premium adjustments for the CMS and Medicaid risk corridor programs are accounted for as premium adjustments subject to retrospectively rated features (see Note 24). Premium adjustments for the ACA Section 1343 risk adjustment, CMS risk adjustment, and Medicaid performance programs are accounted for as premium adjustments subject to redetermination (see Note 24).

- **Amounts Receivable Relating to Uninsured Plans** — The Company reports amounts due to the Company from CMS, state Medicaid agency/agencies, and groups for the administrative activities it performs for which it has no insurance risk as amounts receivable relating to uninsured plans (see Note 18). Amounts receivable relating to uninsured plans includes the following:

  a) 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. Related cash flows are presented within operating expenses paid within net cash provided by operations in the statutory basis statements of cash flows.

  b) The ACA mandates consumer discounts of 70% in 2019 and 50% in 2018 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. Related cash flows are presented within operating 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.

- **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.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include 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, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These 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 2019 and 2018. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2019; however, actual payments may differ from those established estimates.

The reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

The Company has a contract with the LDH in which the Company processes Full Medicaid Pricing ("FMP") payments to specified providers where the FMP has agreements. The Company records both the amounts collected from the LDH and the amounts disbursed to providers, excluding FMP related premium tax, as net premium income and hospital and medical expense, respectively, in the statutory basis statements of operations. Unsettled FMP payments owed to providers, net of premium tax, of $167,688,518 and $89,367,001 is included in claims unpaid as of December 31, 2019 and 2018, respectively, in the statutory basis statements of admitted assets, liabilities and capital and surplus.

- **Accrued Medical Incentive Pool and Bonus Amounts** — 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 accrued medical incentive pool and bonus amounts 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 accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Aggregate Health Policy Reserves** — 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.

  Aggregate health policy reserves also includes:

  a) 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. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. 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);

  b) CMS risk adjustment payables. The risk adjustment model apportions premiums paid to all health 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. If diagnosis data submitted to CMS needs to be corrected or deleted, the revised diagnosis data can be re-submitted. The Company estimates reductions to risk adjustment revenues and corresponding change in CMS risk adjustment payables 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 (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 estimated amount for PDR (see Note 30).

- **Premiums Received in Advance** — Premiums received in full for the policies processed during the current period, but prior to the commencement of the service period, are recorded as premiums received in advance in the statutory basis statements 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. General expenses due or accrued also include the amounts for unpaid assessments, premium taxes, and the unpaid portion of the contributions required under the ACA risk adjustment and reinsurance programs (see Note 24).

- **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).

- **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.

- **Amounts Due 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 due 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 amounts due from the Company to CMS, state Medicaid agency/agencies, and groups for the administrative activities it performs for which it has no insurance risk (see Note 18). Liability for amounts held under uninsured plans includes the ACA mandates consumer discounts of 70% in 2019 and 50% in 2018 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. Related cash flows are presented within operating 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.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets** — Certain assets, including certain aged premium receivables, certain health care receivables and prepaid expenses, 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 $1,000,000 as of December 31, 2019 and 2018, in compliance with the State of Louisiana requirements for qualification purposes as a domestic insurer. These restricted cash reserves consist principally of industrial and miscellaneous bonds and are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds 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 Louisiana, the LADOI requires the Company to maintain a minimum capital and surplus equal to $3,000,000. The Company has $185,013,910 and $150,247,793 in total statutory basis capital and surplus as of December 31, 2019 and 2018, respectively, which is in compliance with the required amount.

  Risk-based capital ("RBC") is a regulatory tool for measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. The LADOI requires the Company to maintain minimum capital and surplus equal to the greater of the state statute as outlined above, 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 in compliance with the required amount.

- **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 2019 Health Insurer Fee ("HIF") moratorium, no HIF was payable in 2019, therefore no amounts were apportioned out of unassigned surplus in the 2018 statutory basis statements of admitted assets, liabilities, and capital and surplus.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is shown net of reinsurance premiums paid and reinsurance premiums incurred but not paid in the statutory basis statements of operations.

  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 change in reserve for rate credits in the statutory basis statements of operations.

  Pursuant to Section 1343 of the ACA, the Company records premium adjustments for changes to the risk adjustment balances which are reflected in change in reserve for rate credits and net premium income, respectively, in the statutory basis statements of operations.

  Net premium income includes premium under the Medicare Plans which includes CMS premiums, including amounts pursuant to the CMS risk adjustment program, member premiums, and the CMS low-income premium subsidy for the Company's insurance risk coverage. Net premium income is recognized ratably over the period in which eligible individuals are entitled to receive health care services and prescription drug benefits.

  The Company also records estimates related to the CMS risk corridor program. Changes to these estimates are reflected as change in reserve for rate credits in the statutory basis statements of operations.

  The Company's Medicare 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 change in reserve for rate credits in the statutory basis statements of operations.

  Net premium income 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 the Medicaid program. 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. Included in net premium income are capitated payments, home nursing risk-sharing payments, high-dollar risk pool payments, and maternity payments. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

  The Medicaid plan is subject to experience rebates, risk adjustments, and performance guarantees based on various utilization measures. The Company has reported its estimated risk adjustments and experience rebates as change in net premium income and change in reserve for rate credits in the statutory basis statements of operations.

- **Full Medicaid Pricing Pass Through Program** — The LDH and the Company entered into a contract in which the Company processes FMP payments to specified providers where the FMP has agreements. Once received for the LDH, the Company disburses funds from an allocated pool to hospitals, physician groups, and ambulance groups, less any

premium taxes. The funds that have been received cannot be directly linked to a specific claim. Additionally, the Company has no obligation to pay the specified providers until funds have been received. The amounts collected, net of tax, are included in net premium income in the statutory basis statements of operations. FMP receipts of $369,529,001 and $346,377,610 were recorded to net premium income and other medical expenses as of December 31, 2019 and 2018 respectively.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses 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, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the statutory basis statements of operations.

- **General Administrative 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 GAE to be reported in the statutory basis statements of operations.

  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 during the calendar year, 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 GAE 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.

- **Net Investment Income Earned** — Net investment income earned 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 earned (see Note 7).

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred is calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital losses 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 net premium income in the statutory basis statements of operations. Any amounts due to the Company pursuant to this agreement are recorded as amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus (see Note 23).

  The Company has an insolvency-only reinsurance agreement with UnitedHealthcare Insurance Company ("UHIC"), an affiliate whereby 0.01% of net premium income is ceded to UHIC.

- **Amounts Recoverable from Reinsurers** — The Company records amounts recoverable from reinsurers for claims paid pursuant to the reinsurance agreement with Unimerica Insurance Company, Inc., an affiliate in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as net reinsurance payments in the statutory basis statements of operations.

- **Section 1341 ACA Transitional Reinsurance** — The Company has established a receivable of $0 and $45,860 as of December 31, 2019 and 2018, respectively, pursuant to Section 1341 of the ACA which is included in amounts recoverable from reinsurers in the statutory basis statements of admitted assets, liabilities, and capital and surplus, for the transitional reinsurance program. 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).

- **Ceded Reinsurance Premiums Payable** — The ceded reinsurance premiums payable balance represents amounts due to the reinsurer for specified coverage which will be paid based on the contract terms.

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 no commercial customers that individually exceed 10% of total direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, for the years ended December 31, 2019 and 2018.

  Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from members and CMS related to the Medicare Plans as a percentage of total direct premiums written and total premiums and considerations, including receivables for contracts subject to redetermination, are less than 1% as of December 31, 2019 and 2018.

  Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from the State of Louisiana, LDH a percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are approximately 100% as of December 31, 2019 and 98% and 99% as of December 31, 2018, respectively.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2019 and 2018 that have been adopted for 2019 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

No changes in accounting principles have been recorded during the years ended December 31, 2019 and 2018.

During 2018, the Company determined that it had overstated aggregate health policy reserves and increase in reserves for life and accident and health contracts related to premium deficiency reserves by $22,773,000 for the year ended December 31, 2017. In addition, the deferred tax asset as a result of this error was overstated by $4,782,330 for the year ended December 31, 2017. Had the above adjustment been recorded to the 2017 statutory basis financial statements, the increase/(decrease) to net income, total capital and surplus, total assets and total liabilities would have been $22,773,000, $17,990,670, $(4,782,330), and $(22,773,000), respectively. Due to the significance of the error, the cumulative effect of the net income and deferred tax asset of this prior year error was corrected by the Company in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 3, Accounting Changes and Corrections of Errors, and is reflected in the statutory basis statements of changes in capital and surplus as a correction of error and change in net deferred income tax, respectively, for the period ended December 31, 2018.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2019 and 2018, 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 2019 and 2018.

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

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 $163,114 and $278,601, respectively, for 2019 and $29,048 and $124,442, respectively, for 2018. There were no gross realized gains and losses on sales of short-term investments for 2019 and 2018. The net realized loss is included in net realized losses less capital gains benefit in the statutory basis

statements of operations. Total proceeds on the sale of long-term investments were $63,974,963 and $17,709,644 as of December 31, 2019 and 2018, respectively. There were no proceeds on the sale of short-term investments in 2019 and 2018.

As of December 31, 2019 and 2018, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $177,638,046 and $125,032,390, respectively, are as follows:

	2019				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 42,228,395	$ 1,362,226	$ 4,666	$ 50,190	$ 43,535,765
State and agency municipal securities	24,580,972	1,018,193	833	-	25,598,332
City and county municipal securities	49,751,344	1,818,467	-	-	51,569,811
Corporate debt securities	118,253,362	3,287,318	62,379	6,740	121,471,561
Total bonds	$ 234,814,073	$ 7,486,204	$ 67,878	$ 56,930	$ 242,175,469

	2019				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 1,952,324	$ 3,413	$ -	$ -	$ 1,955,737
One to five years	86,138,567	1,618,272	13,491	1,940	87,741,408
Five to ten years	99,608,900	4,424,325	11,368	-	104,021,857
Over ten years	47,114,282	1,440,194	43,019	54,990	48,456,467
Total bonds	$ 234,814,073	$ 7,486,204	$ 67,878	$ 56,930	$ 242,175,469

	2018				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 42,206,761	$ 202,356	$ 115,838	$ 723,252	$ 41,570,027
State and agency municipal securities	32,405,673	65,326	57,845	388,393	32,024,761
City and county municipal securities	74,919,201	94,099	147,400	789,705	74,076,195
Corporate debt securities (includes commercial paper)	82,424,779	134,886	585,441	1,030,075	80,944,149
Total bonds	$ 231,956,414	$ 496,667	$ 906,524	$ 2,931,425	$ 228,615,132

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 $33,580,012 and fair value of $34,296,952.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2019 and 2018:

	2019					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 1,471,061	$ 4,666	$ 6,224,024	$ 50,190	$ 7,695,085	$ 54,856
State and agency municipal securities	829,844	833	-	-	829,844	833
Corporate debt securities	10,002,349	62,379	1,121,687	6,740	11,124,036	69,119
Total bonds	$ 12,303,254	$ 67,878	$ 7,345,711	$ 56,930	$ 19,648,965	$ 124,808

	2018					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 9,361,804	$ 115,838	$ 17,775,912	$ 723,252	$ 27,137,716	$ 839,090
State and agency municipal securities	5,670,244	57,845	20,433,253	388,393	26,103,497	446,238
City and county municipal securities	20,124,624	147,400	44,744,159	789,705	64,868,783	937,105
Corporate debt securities	34,022,101	585,441	35,092,630	1,030,075	69,114,731	1,615,516
Total bonds	$ 69,178,773	$ 906,524	$ 118,045,954	$2,931,425	$ 187,224,727	$3,837,949

The unrecognized 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, 2019 and 2018, 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 an OTTI of $0 and $1,550 as of December 31, 2019 and 2018, respectively, which are included in net realized capital losses less capital gains benefit in the statutory basis statements of operations.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, 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 (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.

(2) The Company did not recognize any OTTIs on loan-backed securities as of December 31, 2019 and 2018.

(3) The Company did not have any loan-backed securities with OTTIs to report by CUSIP as of December 31, 2019 or 2018.

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2019 and 2018:

	2019
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 43,019
2. 12 months or longer	54,990
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	5,382,753
2. 12 months or longer	6,547,982

	2018
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 16,767
2. 12 months or longer	768,266
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	2,669,374
2. 12 months or longer	19,563,680

(5) 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 unrecognized unrealized losses as of December 31, 2019 and 2018 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. **Low-Income Housing Tax Credits** — Not applicable.

L. Restricted Assets —

(1) Restricted assets, including pledged securities as of December 31, 2019 and 2018, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted From Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
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	1,000,000	1,000,000	-	-	1,000,000	-	-
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	$ 1,000,000	$ 1,000,000	$ -	$ -	$ 1,000,000	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 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, 2019 or 2018.

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. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2019 and 2018.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees —

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2019:

	General Account
1. Number of CUSIPs	3
2. Aggregate amount of investment income	$38,771

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–B. 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, 2019 and 2018, are as follows:

	2019			2018			Change		
	1	2	3	4	5	6	7	8	9
	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) Gross deferred tax assets	$13,585,830	$ 13	$13,585,843	$14,966,439	$ 13	$14,966,452	$(1,380,609)	$ -	$(1,380,609)
(b) Statutory valuation allowance adjustments	-	-	-	-	-	-	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	13,585,830	13	13,585,843	14,966,439	13	14,966,452	(1,380,609)	-	(1,380,609)
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	13,585,830	13	13,585,843	14,966,439	13	14,966,452	(1,380,609)	-	(1,380,609)
(f) Deferred tax liabilities	288,750	3,283	292,033	373,655	1,347	375,002	(84,905)	1,936	(82,969)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$13,297,080	$ (3,270)	$13,293,810	$14,592,784	$ (1,334)	$14,591,450	$(1,295,704)	$ (1,936)	$(1,297,640)

(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:

	2019			2018			Change		
Admission Calculation Components SSAP No. 101	1 Ordinary	2 Capital	3 (Col 1 + 2) Total	4 Ordinary	5 Capital	6 (Col 4 + 5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7 + 8) Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$ 13,585,830	$ -	$ 13,585,830	$ 14,966,439	$ 13	$ 14,966,452	$(1,380,609)	$ (13)	$(1,380,622)
(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)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	17,172,010	XXX	XXX	13,565,634	XXX	XXX	3,606,376
(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	-	13	13	-	-	-	-	13	13
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 13,585,830	$ 13	$ 13,585,843	$ 14,966,439	$ 13	$ 14,966,452	$(1,380,609)	$ -	$(1,380,609)

(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:

	2019	2018
(a) Ratio percentage used to determine recovery period and threshold limitation amount	249 %	255 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 171,720,100	$ 135,656,343

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2019 and 2018, is presented below:

	2019		2018		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)	$ 13,585,830	$ 13	$ 14,966,439	$ 13	$ (1,380,609)	$ -
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)	13,585,830	13	14,966,439	13	(1,380,609)	-
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, 2019 and 2018.

C. Significant Components of Income Taxes

(1) The current federal and foreign income taxes incurred for the years ended December 31, 2019 and 2018 are as follows:

	1	2	3
	2019	2018	(Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 7,633,194	$ 9,072,302	$ (1,439,108)
(b) Foreign	-	-	-
(c) Subtotal	7,633,194	9,072,302	(1,439,108)
(d) Federal income tax on net capital gains (losses)	(15,440)	(16,237)	797
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred	$ 7,617,754	$ 9,056,065	$ (1,438,311)

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2019 and 2018, are as follows:

	1 2019	2 2018	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 1,022,393	$ 809,482	$ 212,911
(2) Unearned premium reserve	5,956	7,447	(1,491)
(3) Policyholder reserves	4,878,930	9,169,650	(4,290,720)
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	7,678,158	4,978,992	2,699,166
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carryforward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	393	868	(475)
(99) Subtotal	13,585,830	14,966,439	(1,380,609)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	13,585,830	14,966,439	(1,380,609)
(e) Capital:			
(1) Investments	-	-	-
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	13	13	-
(99) Subtotal	13	13	-
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	13	13	-
(i) Admitted deferred tax assets (2d + 2h)	13,585,843	14,966,452	(1,380,609)
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	23,956	19,851	4,105
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	264,794	353,804	(89,010)
(99) Subtotal	288,750	373,655	(84,905)
(b) Capital:			
(1) Investments	3,212	1,347	1,865
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	71	-	71
(99) Subtotal	3,283	1,347	1,936
(c) Deferred tax liabilities (3a99 + 3b99)	292,033	375,002	(82,969)
4 Net deferred tax assets/liabilities (2i - 3c)	$ 13,293,810	$ 14,591,450	$(1,297,640)

The other capital deferred tax asset of $13 for 2019 and 2018 consist of unrealized losses. The other ordinary deferred tax liability of $264,794 for 2019 consists of discounting of unpaid losses. The other ordinary deferred tax liability of $353,804 of 2018 consists of discounting of unpaid loss of $352,087 and $1,717 of premium acquisition expenses.

The Company assessed the potential realization of the gross deferred tax asset and as a result no statutory valuation allowance was required and no allowance was established as of December 31, 2019 and 2018.

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 21% to net income before federal income taxes incurred, plus capital losses/less capital gains benefit. A summarization of the significant items causing this difference as of December 31, 2019 and 2018 is as follows:

	2019		2018	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 11,872,127	21 %	$ 417,699	21 %
Tax-exempt interest	(257,722)	(1)	(291,711)	(14)
Health insurer fee	-	-	8,967,120	451
Tax effect of nonadmitted assets	(2,699,082)	(5)	(2,619,155)	(132)
Prior year true-up	6,716,220	12	-	-
Prior year audited financial statement adjustment, net with true-up above	(4,789,890)	(8)	-	-
Deferred corrections	(1,926,330)	(3)	4,782,330	240
Total statutory income taxes	$ 8,915,323	16 %	$ 11,256,283	566 %
Federal income taxes incurred	$ 7,633,194	14 %	$ 9,072,302	456 %
Capital gains tax	(15,440)	-	(16,237)	(1)
Change in net deferred income tax	1,297,569	2	2,200,218	111
Total statutory income taxes	$ 8,915,323	16 %	$ 11,256,283	566 %

E. At December 31, 2019, the Company had no net operating loss carryforwards.

Current federal income taxes payable of $4,258,754 and $18,724,065 as of December 31, 2019 and 2018, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $22,083,065 and $1,243,692 in 2019 and 2018, respectively.

Federal income taxes incurred of $7,617,755 and $9,056,065 for 2019 and 2018, 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 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, 2018 and 2019 tax returns are under 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 the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2014 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–O. Material Related Party Transactions

Management believes that the Company's 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.

In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the LADOI according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) PMPM; (5) per employee per month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These amounts are included in GAE and CAE in the statutory basis statements of operations. The following table identifies the amounts for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2019 and 2018, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties*, regardless of the effective date of the contract:

	2019	2018
OptumRx	$ 427,129,037	$ 88,051,257
United HealthCare Services, Inc.	127,999,185	137,570,046
United Behavioral Health	26,448,952	24,884,921
AxelaCare Intermediate Holdings, LLC	8,787,370	8,590,820
OptumInsight, Inc.	3,213,028	3,286,049

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products.

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, provider networks, quality oversight and wellness management. The amount charged to the Company for the management and operational services provided by UHS are calculated pursuant to the Agreement.

United Behavioral Health provides services related to mental health and substance abuse treatment.

AxelaCare Intermediate Holdings, LLC provides home infusion therapy services.

OptumInsight, Inc. provides services that may include, but are not limited to, claim analytics and 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.

The Company has premium payments that are received, claim payments and direct expenses such as broker commissions, LADOI exam fees, ACA assessments, and premium taxes that are processed and paid by an affiliated UnitedHealth Group entity. Premiums, claims and direct expenses 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 amounts due to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

The Company holds a $100,000,000 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 credit agreement is effective until terminated by either party. No amounts were outstanding under the line of credit as of December 31, 2019 and 2018.

The Company has a Tax Sharing Agreement with UnitedHealth Group (see Note 9).

The Company did not pay any dividends in 2019 or 2018 (see Note 13).

The Company has entered into a reinsurance agreement with an affiliated entity (see Note 23).

At December 31, 2019 and 2018, the Company reported $11,436,936 and $11,555,554, respectively, as amounts due 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.

The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

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, controlled, or affiliated entity.

The Company does not have any investments in a subsidiary, 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 does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2019 and 2018.

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 1,000,000 shares authorized and 900,000 shares issued and outstanding of $2 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, UHC.

(3) Payment of dividends may be restricted by the LADOI, which generally requires that dividends be paid out of unassigned surplus.

(4) The Company paid no dividends and no infusions were received during 2019 or 2018.

(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, 2019, the amount of the estimated Section 9010 ACA subsequent fee year assessment apportioned out of unassigned surplus was $43,016,618. As discussed in Note 1, in 2018 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, correction of error, and net income (loss), represented (or reduced) by each item below is as follows:

	2019	2018	Change
Unrealized capital gains (losses) on investments	$ 276	$ (62)	$ 338
Net deferred income taxes	13,293,810	14,591,450	(1,297,640)
Nonadmitted assets	(36,562,656)	(23,709,891)	(12,852,765)
Total	$ (23,268,570)	$ (9,118,503)	$ (14,150,067)

(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

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

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. 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.

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 made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

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 other assets that the Company considers to be impaired at December 31, 2019 and 2018, except as disclosed in Note 5.

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–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2019 and 2018.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a receivable in amounts receivable relating to uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus of $185,911 and $260,743 at December 31, 2019 and 2018, respectively, 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 $31,823 and $13,297 and also a payable of $52,913 and $24,205 at December 31, 2019 and 2018, 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 participates in administrating payments for the LDH's Managed Care Incentive Program ("MCIP"), which incentivizes hospitals to meet certain individualized metrics. Once a hospital meets these incentives, they are compensated for their efforts in helping the Medicaid populations. There is no risk to the Company as a result of these transactions. The Company has recorded a payable of $0 as of December 31, 2019, which is included in liability for amounts held under uninsured plans in the statutory basis statements of admitted assets, liabilities, and capital and surplus for the additional pass-through payments to providers. The payments processed for the MCIP were $34,269,790 as of December 31, 2019.

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 2019 and 2018.

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.

The estimated fair values of bonds and cash equivalents 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 tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2019 and 2018, 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:

	December 31, 2019				
Description for Each Class of Asset or Liability	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	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	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stock	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	177,592,989	-	-	-	177,592,989
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 177,592,989	$ -	$ -	$ -	$ 177,592,989
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2018 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	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	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stock	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	123,843,352	-	-	-	123,843,352
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 123,843,352	$ -	$ -	$ -	$ 123,843,352
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

(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, 2019 or 2018.

(4) The Company has no investments reported with a fair value hierarchy of Level 2 or Level 3 and therefore has no valuation technique to disclose.

(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, 2019 and 2018 is presented in the table below:

	December 31, 2019						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 43,535,765	$ 42,228,395	$ 10,931,140	$ 32,604,625	$ -	$ -	$ -
State and agency municipal securities	25,598,332	24,580,972	-	25,598,332	-	-	-
City and county municipal securities	51,569,811	49,751,344	-	51,569,811	-	-	-
Corporate debt securities	121,471,561	118,253,362	-	121,471,561	-	-	-
Cash equivalents	177,592,989	177,592,989	177,592,989	-	-	-	-
Total bonds and cash equivalents	$ 419,768,458	$ 412,407,062	$ 188,524,129	$ 231,244,329	$ -	$ -	$ -

	December 31, 2018						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 41,570,027	$ 42,206,761	$ 13,413,831	$ 28,156,196	$ -	$ -	$ -
State and agency municipal securities	32,024,761	32,405,673	-	32,024,761	-	-	-
City and county municipal securities	74,076,195	74,919,201	-	74,076,195	-	-	-
Corporate debt securities	80,944,149	82,424,779	-	80,944,149	-	-	-
Cash equivalents	123,843,352	123,843,352	123,843,352	-	-	-	-
Total bonds and cash equivalents	$ 352,458,484	$ 355,799,766	$ 137,257,183	$ 215,201,301	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — 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, 2019 and 2018.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2019 and 2018.

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 2019 and 2018.

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.

(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, 2019, the Company is not aware of any possible proceeds of insurance-linked securities.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through April 27, 2020, which is the date these statutory basis financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2019, have been recognized in the statutory basis financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

The Company is subject to the annual fee under Section 9010 of the ACA. The 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. The HIF was repealed by Congress effective January 1, 2021.

As of December 31, 2019, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2020, and estimates its portion of the annual health insurance industry fee payable on September 30, 2020 to be $43,016,618. This amount has been apportioned out of unassigned surplus and is reflected as Section 9010 ACA subsequent fee year assessment in the statutory basis financial statements. In accordance with the 2019 HIF moratorium, no amounts were required to be apportioned out of unassigned surplus in 2018 (see Note 1). The

Company's Authorized Control Level RBC ("ACL RBC") ratio was 271% as of December 31, 2019. Reporting the ACA assessment as a liability as of December 31, 2019, would not have triggered an RBC action level.

The table below presents information regarding the annual fee under Section 9010 of the ACA as of December 31, 2019 and 2018:

		2019		2018
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	$ 43,016,618	$	-
C.	ACA fee assessment paid	-		42,700,576
D.	Premium written subject to ACA 9010 assessment	2,255,081,823		-
E.	Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	185,013,910		
F.	Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	141,997,292		
G.	Authorized Control Level (Five-Year Historical Line 15)	66,594,139		
H.	Would reporting the ACA assessment as of December 31, 2019, have triggered an RBC action level (Yes/No)?	No		

There are no other material non-recognized Type II events 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 and other nonaffiliated reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company has an insolvency-only reinsurance agreement with UHIC, an affiliate of the Company, to provide insolvency protection for its enrollees. Reinsurance premiums, which are calculated on a percentage of member premium income, of $1,986,310 and $1,889,471 in 2019 and 2018, respectively, are netted against net premium income in the statutory basis statements of operations.

The Company entered into a reinsurance agreement with an affiliated entity, Unimerica Insurance Company, Inc. to cede obligations relating to mental health and substance use disorder benefits and chiropractic, physical and occupational therapy treatments benefits. This reinsurance agreement was terminated effective December 31, 2017. Run-out insurance premiums of $570,867 as of December 31, 2018 were netted against net premium income in the statutory basis statements of operations. Reinsurance recoveries of ($693,240) and ($6,663,928) as of December 31, 2019 and 2018, respectively are included in net reinsurance recoveries in the statutory basis statements of operations. There were $225,986 of amounts recoverable from reinsurers related to this agreement as of December 31, 2018. 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.

The Company does not have any unaffiliated reinsurance agreements in place as of December 31, 2019 or 2018.

Pursuant to Section 1341 of ACA, through 2017, the Company was subject to the reinsurance provisions for compliant individual policies (see Note 24).

The effect of internal and external reinsurance agreements outlined above on net premium income and hospital and medical expenses is presented below:

	2019	2018
Premiums:		
Direct	$ 2,344,955,006	$ 2,257,443,108
Ceded:		
Affiliate	1,986,310	2,460,337
Net premium income	$ 2,342,968,696	$ 2,254,982,771
Hospital and medical expenses:		
Direct	$ 2,012,943,549	$ 1,889,217,023
Ceded:		
Affiliate	(693,240)	(6,663,928)
Nonaffiliate	36,185	-
Net hospital and medical expenses	$ 2,013,600,604	$ 1,895,880,951

The Company recognized reinsurance recoveries related to internal and external reinsurance agreements of $(657,055) and $(6,663,928) in 2019 and 2018, respectively, which are recorded as net reinsurance recoveries in the statutory basis statements of operations. In addition, reinsurance recoverables related to internal and external reinsurance agreements of $0 and $271,846 for paid losses are recorded as amounts recoverable from reinsurers and $(1,245) and $227,522 for unpaid losses are recorded as a reduction to claims unpaid in 2019 and 2018, 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 ( ) No (X)

(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, 2019.

(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 2019 and 2018, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2019 or 2018.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — 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 (from) the Company are recorded in premiums and considerations and aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in unearned premium reserves and reserve for rate credits 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 and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by the ACA. The total amount of direct premiums written for the commercial lines of business subject to the retrospectively rated and redetermination features was $2,828,201 and $47,082,203, representing 0.1% and 2.2% of total direct premiums written as of December 31, 2019 and 2018, 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 $9,355,681 and $5,085,865, representing 0.4% and 0.2% of total direct premiums written as of December 31, 2019 and 2018, 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 $553,351 and $370,152 representing, 0.1% and less than 0.1% of total direct premiums written for 2019 and 2018, 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 $9,355,681 and $5,085,865 representing, 0.4% and 0.2% of total direct premiums written for 2019 and 2018, respectively.

CMS has released the final Medicaid Managed Care Rule which is subject to each State's administration elections. This rule is the first major update to the Medicaid Managed Care regulations in more than a decade. Many items including a minimum loss ratio requirement were implemented for contracts with an effective date starting on or after July 1, 2017 while other elements of the regulation will be implemented over the following decade. Pursuant to the regulations, for contracts effective on or after July 1, 2017 premiums associated with the Company's Medicaid line of business is subject to retrospectively rated features based on the actual medical loss ratios experienced on this product. The calculation is pursuant to the Medicaid Managed Care guidance. The total amount of direct premiums written for the Medicaid line of business for which a portion is subject to the retrospectively rated features was $2,332,771,124 and $1,858,897,429, representing 99.5% and 82.3% of total direct premiums written as of December 31, 2019 and December 31, 2018, respectively.

The Medicaid contract, with the State of Louisiana has risk adjustment amounts from LDH which are subject to a redetermination feature related to Medicaid premiums. The Company has estimated premium adjustments based on guidelines by LDH. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the redetermination feature was $2,332,771,124 and $1,858,897,429, representing 99.5% and 82.3% of the Company's total direct premiums written as of December 31, 2019 and 2018, respectively.

The Medicaid contract, with the State of Louisiana includes a provision for which a stated percentage of total direct premiums written can be eligible for a performance guarantee payment, based on various quality measures. The total amount of direct premiums written from the Medicaid contract, for which a portion is subject to the redetermination feature was $2,332,771,124 and $1,858,897,429, representing 99.5% and 82.3%, of the Company's total direct premiums written, as of December 31, 2019 and 2018, respectively.

The Medicaid contract with the State of Louisiana includes a retrospectively rated feature related to the Value Added Benefits and Services program. The Company has estimated accrued retrospective premiums pursuant to the contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated feature was $1,858,897,429, representing 82.3% of the Company's total direct premiums written as of December 31, 2018.

The Medicaid contract with the State of Louisiana includes a retrospectively rated feature related to the Hepatitis C Risk corridor program. The Company has estimated accrued retrospective premiums pursuant to the contract. The total amount of direct premiums written from the Medicaid contract for which a portion is subject to the retrospectively rated feature was $2,332,771,224 representing 99.5% of the Company's total direct premiums written as of December 31, 2019.

D. The Company is required to maintain specific minimum loss ratios on the comprehensive commercial and Medicare lines of business. The Company's actual loss ratios on the comprehensive commercial and Medicare lines of business were in excess of the minimum requirements and as a result, no minimum medical loss ratio rebate liability was required to be established at December 31, 2019 and 2018.

Pursuant to the Medicaid Managed Care Rule based on state contractual minimum loss ratio requirements, the Company is required to maintain specific minimum loss ratios on its Healthy Louisiana and Healthy Louisiana populations. The Company has estimated $36,273,605 and $35,664,587 in estimated Medicaid Managed Care Rule rebates as of December 31, 2019 and December 31, 2018, respectively, which is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2019 and 2018 subject to the risk-sharing provisions of the ACA.

The ACA imposed 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 corridors.

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. Effective for 2018 benefit plan year, the risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. The operation of the high-cost risk pools exclude a percentage of costs above a threshold level determined by federal regulations. The program operates two national high-cost risk pools, one for individuals and one for small groups. The data used by CMS to determine the risk adjustment amount is subject to risk adjustment data validation audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded. 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:

		December 31, 2019
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high risk pool payments)	$ 6,381
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	240
3.	Premium adjustments payable due to ACA Risk Adjustment (including high risk pool premium)	122,193
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	(156,288)
5.	Reported in expenses as ACA risk adjustment user fees (incurred/paid)	242
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ -
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	36,185
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)	-
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(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	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium Adjustment Receivable (including high risk pool payments)	$ 15,547	$ -	$ 15,547	$ -	$ -	$ -	$ 5,407	$ -	A	$ 5,407	$ -
2. Premium Adjustment (Payable) (including high risk pool premium)	-	(163,200)	-	(203,676)	-	40,476	-	(40,476)	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	15,547	(163,200)	15,547	(203,676)	-	40,476	5,407	(40,476)		5,407	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	45,860	-	82,045	-	(36,185)	-	36,185	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	45,860	-	82,045	-	(36,185)	-	36,185	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	-	-	-	-	-	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ 61,407	$ (163,200)	$ 97,592	$ (203,676)	$ (36,185)	$ 40,476	$ 41,592	$ (40,476)		$ 5,407	$ -

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2019 was adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year. The risk adjustment receivable as of December 31, 2018 utilized paid claims through October 31, 2018. The adjustment to the December receivable balance reflects the true up to final results for the 2018 Benefit Year. The risk adjustment receivable was further adjusted based on the CMS Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers.

B. The risk adjustment payable as of December 31, 2019 was adjusted based on the final CMS Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year. The risk adjustment payable as of December 31, 2018 utilized paid claims through October 31, 2018. The adjustment to the December payable balance reflects the true up to final results for the 2018 Benefit Year. The risk adjustment payable as of December 31, 2019 was further adjusted based on the CMS Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers.

C. Actual reinsurance receipts exceeded anticipated results due to a higher final coinsurance rate.

D. N/A

E. N/A

F. N/A

G. N/A

H. N/A

I. N/A

J. N/A

(4) The Company does not have any risk corridor receivables or payables to present in the table below.

Risk Corridors Program Year	Accrued during the Prior Year on Business Written before December 31 of the Prior Year 1 Receivable	Accrued during the Prior Year on Business Written before December 31 of the Prior Year 2 (Payable)	Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year 3 Receivable	Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year 4 (Payable)	Differences Prior Year Accrued Less Payments (Col 1 - 3) 5 Receivable	Differences Prior Year Accrued Less Payments (Col 2 - 4) 6 (Payable)	Adjustments To Prior Year Balances 7 Receivable	Adjustments To Prior Year Balances 8 (Payable)	Ref	Unsettled Balances as of the Reporting Date Cumulative Balance from Prior Years (Col 1 - 3 + 7) 9 Receivable	Unsettled Balances as of the Reporting Date Cumulative Balance from Prior Years (Col 2 - 4 + 8) 10 (Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	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	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -

Explanation of Adjustments

A. N/A
B. N/A
C. N/A
D. N/A
E. N/A
F. N/A

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-Admissions) (1 - 2 - 3)	5 Non-Admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	4,251,826	4,251,826	-	-	-	-
c. 2016	209,226	209,226	-	-	-	-
d. Total (a + b + c)	$ 4,461,052	$ 4,461,052	$ -	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables and reinsurance recoverables for the years ended December 31, 2019 and 2018:

	2019		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (249,603,543)	$ (249,603,543)
Paid claims — net of health care receivables and reinsurance recoveries collected	1,765,087,819	185,001,624	1,950,089,443
End of year claim reserve	285,432,095	33,439,407	318,871,502
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	2,050,519,914	(31,162,512)	2,019,357,402
Beginning of year health care receivables and reinsurance recoverables	-	33,603,739	33,603,739
End of year health care receivables and reinsurance recoverables	(2,642,606)	(36,717,931)	(39,360,537)
Total incurred claims	$ 2,047,877,308	$ (34,276,704)	$ 2,013,600,604

	2018		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (234,053,825)	$ (234,053,825)
Paid claims — net of health care receivables and reinsurance recoveries collected	1,711,424,208	156,138,681	1,867,562,889
End of year claim reserve	237,606,753	11,996,790	249,603,543
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	1,949,030,961	(65,918,354)	1,883,112,607
Beginning of year health care receivables and reinsurance recoverables	-	46,372,083	46,372,083
End of year health care receivables and reinsurance recoverables	(11,769,211)	(21,834,528)	(33,603,739)
Total incurred claims	$ 1,937,261,750	$ (41,380,799)	$ 1,895,880,951

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care receivables and reinsurance recoverables as of December 31, 2018 was $215,999,804. As of December 31, 2019, $185,001,624 has been paid

for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables and reinsurance recoverables are now ($3,278,524), as a result of re-estimation of unpaid claims. Therefore, there has been $34,276,704 favorable prior year development since December 31, 2018 to December 31, 2019. The primary drivers consist of favorable development of $25,883,178 in retroactivity for inpatient, outpatient, physician, and pharmacy claims and favorable development as a result of a change in the provision for adverse deviations in experience of $7,570,058.

At December 31, 2018, the Company recorded $41,380,799 of favorable development as a result of a change in the provider gain share provisions of $29,244,163, favorable development of $17,965,966 in retroactivity for inpatient, outpatient, physician, and pharmacy claims and favorable development of $5,871,255 as a result of a change in the provision for adverse deviations in experience, offset by unfavorable development of $11,555,552 in behavioral and other health reserves. Original estimates are increased or decreased, as additional information becomes known regarding individual claims, which could have an impact to the accruals for medical loss ratio rebates and retrospectively rated contracts. 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 change in reserve for rate credits in the statutory basis statements of operations.

The Company incurred CAE of $95,129,543 and $88,909,905 in 2019 and 2018, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2019 and 2018:

	2019	2018
Total claims adjustment expenses	$ 95,129,543	$ 88,909,905
Less current year unpaid claims adjustment expenses	(1,111,430)	(1,351,967)
Add prior year unpaid claims adjustment expenses	1,351,967	1,370,586
Total claims adjustment expenses paid	$ 95,370,080	$ 88,928,524

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2019.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2019 or 2018.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2019 or 2018.

28. HEALTH CARE RECEIVABLES

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
12/31/2019	$ 985,672	$ -	$ -	$ -	$ -
9/30/2019	532,900	1,008,564	155,944	-	-
6/30/2019	2,110,736	2,661,764	1,710,608	787,932	-
3/31/2019	5,890,908	6,014,316	3,300,991	1,715,908	681,083
12/31/2018	7,084,291	6,941,159	4,797,119	1,840,214	92,733
9/30/2018	6,505,071	6,508,045	3,843,911	2,059,957	524,916
6/30/2018	6,775,195	6,685,348	3,797,795	2,248,025	567,565
3/31/2018	6,788,436	6,536,372	3,031,387	2,776,322	681,224
12/31/2017	6,505,624	6,531,690	3,462,157	2,780,431	275,131
9/30/2017	6,070,663	5,812,606	2,392,970	2,847,846	540,421
6/30/2017	6,470,423	5,832,036	997,521	3,952,323	875,530
3/31/2017	6,412,539	5,850,962	553,168	4,057,423	1,203,022

Of the amount reported as health care receivable, $1,838,636 and $9,878,575 relates to pharmacy rebates receivable as of December 31, 2019 and 2018, respectively. This decrease is primarily due to the change in benefit design.

B. The Company does not have any risk-sharing receivables.

The Company has admitted claim overpayments of $975,414 and $258,655 in 2019 and 2018, respectively, which are included in health care receivables in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2019 or 2018.

30. PREMIUM DEFICIENCY RESERVES

The following table summarizes the Company's PDR as of December 31, 2019 and 2018:

		2019
1. Liability carried for premium deficiency reserves	$	23,233,000
2. Date of the most recent evaluation of this liability		12/31/2019
3. Was anticipated investment income utilized in this calculation?	Yes [X]	No [ ]

		2018
1. Liability carried for premium deficiency reserves	$	43,655,000
2. Date of the most recent evaluation of this liability		12/31/2018
3. Was anticipated investment income utilized in this calculation?	Yes [X]	No [ ]

PDR is included in aggregate health policy reserves (see Note 1 — *Basis of Presentation*) in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2019 and 2018, 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 claims unpaid and aggregate health claim reserves.

32. RECONCILIATION TO THE ANNUAL STATEMENT

During the audit of 2019 statutory basis financial statements, necessary adjustments were discovered during the subsequent event review related to changes in the PDR from what was previously filed by the Company to the 2019 Annual submission on March 1, 2020.

The following table reconciles the 2019 Annual Statement previously filed to the 2019 statutory basis financial statements:

	Per Audited Statutory Basis Financial Statements	Per Annual Statement	Variance
Assets	$ 626,088,108	$ 627,272,088	$ (1,183,980)
Liabilities	441,074,198	446,712,198	(5,638,000)
Capital and surplus	185,013,910	180,559,890	4,454,020
Expenses	2,299,158,018	2,327,605,018	(28,447,000)
Net income	48,916,184	20,469,184	28,447,000

The following table is also provided for additional information regarding the impact of the adjustments to capital and surplus:

Capital and surplus per annual statement	$ 180,559,890
Change in net deferred income taxes	(1,183,980)
Adjustment to decrease in reserves for accident and health contracts	5,638,000
Capital and surplus per statutory basis financial statements	$ 185,013,910

The following table is also provided for additional information regarding the impact of the adjustments to 2019 net income:

Net loss per annual statement	$ 20,469,184
Adjustment to decrease in reserves for accident and health contracts	28,447,000
Net income per statutory basis financial statements	$ 48,916,184

The result of the adjustments made to the 2019 statutory basis financial statements is an increase to total capital and surplus of $4,454,020 and an increase in net income of $28,447,000.

During 2018, the Company determined that it had overstated the PDR for the year ended December 31, 2017. In 2018, the Company reflected this change as a correction of error in the statutory basis statements of changes in capital and surplus (see Note 2). During the audits of the 2018 and 2017 statutory basis financial statements, necessary adjustments were discovered during the subsequent event review related to changes in the PDR from what was previously filed by the Company with the LADOI. The below adjustments for 2018 were the result of a change in estimate based on new information received subsequent to the 2018 Annual Statement submission on March 1, 2019, and the 2017 adjustments that were reported in the 2018 Annual Statement field by the Company with the LADOI.

The following table reconciles the 2018 Annual Statement previously filed to the 2018 statutory basis financial statements:

	Per Audited Statutory Basis Financial Statements	Per Annual Statement	Variance
Assets	$ 566,939,918	$ 562,150,028	$ 4,789,890
Liabilities	416,692,125	393,883,125	22,809,000
Capital and surplus	150,247,793	168,266,903	(18,019,110)
Expenses	2,256,655,453	2,253,197,453	3,458,000
Net income	(7,067,021)	(3,609,021)	(3,458,000)

The following table is also provided for additional information regarding the impact of the adjustments to capital and surplus:

Capital and surplus per annual statement	$ 168,266,903
Adjustment to net deferred income taxes	4,789,890
Adjustment to decrease in reserves for accident and health contracts	(22,809,000)
Capital and surplus per statutory basis financial statements	$ 150,247,793

The following table is also provided for additional information regarding the impact of the adjustments to 2018 net income:

Net loss per annual statement	$ (3,609,021)
Adjustment to decrease in reserves for accident and health contracts	(3,458,000)
Net income per statutory basis financial statements	$ (7,067,021)

The result of the adjustments made to the 2018 statutory basis financial statements is a net decrease in total capital and surplus of $18,019,110 and a decrease in net income of $3,458,000.

* * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2019
(To Be Filed by April 1)

Of The UnitedHealthcare of Louisiana, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 95833 Federal Employer's Identification Number (FEIN) 72-1074008

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. $ 626,088,108

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	Goldman Sachs - FGTXX	Bonds	$ 25,517,494	4.1 %
2.02	DEUTSCHE GOV - ICAXX	Bonds	$ 24,248,270	3.9 %
2.03	HSBC - HGIXX	Bonds	$ 23,664,647	3.8 %
2.04	TUGXX US Equity - TUGXX	Bonds	$ 22,151,464	3.5 %
2.05	Fannie Mae	Bonds	$ 10,915,886	1.7 %
2.06	FHLMC	Bonds	$ 10,710,255	1.7 %
2.07	Dreyfus - DGCXX	Bonds	$ 10,354,709	1.7 %
2.08	Morgan Stanley Institutional - MVRXX	Bonds	$ 5,573,333	0.9 %
2.09	Invesco AIM - AGPXX	Bonds	$ 3,858,253	0.6 %
2.10	BANK OF AMERICA	Bonds	$ 3,857,982	0.6 %

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	$ 199,396,193	31.8 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 35,417,880	5.7 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	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 [X] No [ ]

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	$ 0	0.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	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:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	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			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

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 [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	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 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 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 1 Amount	Gross Investment Holdings 2 Percentage of Column 1 Line 13	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	20,602,255	4.995	20,602,255	0	20,602,255	4.995
	1.02 All other governments	0	0.000	0	0	0	0.000
	1.03 U.S. states, territories and possessions, etc. guaranteed	11,114,598	2.695	11,114,598	0	11,114,598	2.695
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	26,310,621	6.379	26,310,621	0	26,310,621	6.379
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	57,702,561	13.990	57,702,561	0	57,702,561	13.990
	1.06 Industrial and miscellaneous	119,084,038	28.872	119,084,038	0	119,084,038	28.872
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
	1.11 Total long-term bonds	234,814,073	56.931	234,814,073	0	234,814,073	56.931
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment trusts	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B):						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	0	0.000	0	0	0	0.000
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A):						
	5.01 Properties occupied by company	0	0.000	0	0	0	0.000
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments:						
	6.01 Cash (Schedule E, Part 1)	45,057	0.011	45,057	0	45,057	0.011
	6.02 Cash equivalents (Schedule E, Part 2)	177,592,989	43.058	177,592,989	0	177,592,989	43.058
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	177,638,046	43.069	177,638,046	0	177,638,046	43.069
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	0	0.000	0	0	0	0.000
10.	Receivables for securities	0	0.000	0	0	0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	412,452,119	100.000	412,452,119	0	412,452,119	100.000

OTHER ATTACHMENT

Deloitte.

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To the Audit Committee of
UnitedHealthcare of Louisiana, Inc.
3838 North Causeway Boulevard, Suite 2600
Metairie, LA 70002

The Management of
UnitedHealthcare of Louisiana, Inc.
3838 North Causeway Boulevard, Suite 2600
Metairie, LA 70002

Dear Members of the 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 of Louisiana, Inc. (the "Company") for the years ended December 31, 2019, and 2018, and have issued our report thereon dated April 27, 2020. In connection therewith, we advise you as follows:

1. 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 Louisiana Department of Insurance, and the Rules of Professional Conduct of the Minnesota State Board of Accountancy.

2. The engagement managing director and engagement manager, who are certified public accountants, have 15 years and 7 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 33% percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory basis financial statements and our report thereon with the Louisiana Department of Insurance 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 Louisiana Department of Insurance. 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 Louisiana Department of Insurance.

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.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Louisiana Department of Insurance has filed a Report of Examination covering 2019, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Louisiana Department of Insurance or its delegates, at the offices of the insurer, at our offices, at the Louisiana Department of Insurance, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Louisiana Department of Insurance, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Louisiana Department of Insurance. In addition, to the extent requested, we may provide the Louisiana Department of Insurance with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Louisiana Department of Insurance or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Louisiana Department of Insurance; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement managing director has served in this capacity with respect to the Company since 2019, is licensed by the Minnesota State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. 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 of Louisiana, Inc. and for filing with the Louisiana Department of Insurance 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

April 27, 2020

UnitedHealthcare of Louisiana, Inc.

Statutory Basis Financial Statements as of and for the Years Ended December 31, 2020 and 2019, Supplemental Schedules as of and for the Year Ended December 31, 2020, Independent Auditors' Report and Qualification Letter

UNITEDHEALTHCARE OF LOUISIANA, INC.

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INDEPENDENT AUDITORS' REPORT

To the Audit Committee of
UnitedHealthcare of Louisiana, Inc.
3838 N. Causeway Boulevard, Suite 2600
Metairie, LA 70002

We have audited the accompanying statutory basis financial statements of UnitedHealthcare of Louisiana, Inc. (the "Company"), which comprise the statutory basis statements of admitted assets, liabilities, and capital and surplus as of December 31, 2020 and 2019, 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 Louisiana Department of Insurance. 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 audit 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 of Louisiana, Inc. as of December 31, 2020 and 2019, 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 Louisiana Department of Insurance 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 of Louisiana, Inc. using accounting practices prescribed or permitted by the Louisiana Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the Louisiana Department of Insurance. Our opinion is not modified with respect to this matter.

Report on Supplemental Schedules

Our 2020 audit was conducted for the purpose of forming an opinion on the 2020 statutory basis financial statements as a whole. The supplemental schedule of investment risks interrogatories and the supplemental summary investment schedule, and the supplemental schedule of reinsurance contracts with risk -limiting features as of and for the year ended December 31, 2020 are presented for purposes of additional analysis and are not a required part of the 2020 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 2020 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 2020 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 of Louisiana, Inc. 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

April 16, 2021

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND CAPITAL AND SURPLUS AS OF DECEMBER 31, 2020 AND 2019

	2020	2019
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 241,426,031	$ 234,814,073
Cash of $52,653 and $45,057, and cash equivalents of $262,697,267 and $177,592,989, in 2020 and 2019, respectively	262,749,920	177,638,046
Other invested assets	2,434,863	-
Subtotal cash and invested assets	506,610,814	412,452,119
OTHER ASSETS:		
Investment income due and accrued	2,093,990	2,304,540
Premiums and considerations	208,368,365	195,005,855
Amounts receivable relating to uninsured plans	175,058	217,734
Net deferred tax asset	13,860,345	13,293,810
Health care receivables	1,724,492	2,814,050
Subtotal other assets	226,222,250	213,635,989
TOTAL ADMITTED ASSETS	$ 732,833,064	$ 626,088,108
LIABILITIES AND CAPITAL AND SURPLUS		
LIABILITIES:		
Claims unpaid	$ 329,472,987	$ 305,410,683
Accrued medical incentive pool and bonus amounts	2,391,012	10,916,024
Unpaid claims adjustment expenses	1,427,483	1,111,430
Aggregate health policy reserves	65,812,140	59,629,719
Aggregate health claim reserves	3,257,501	2,544,795
Premiums received in advance	320,182	141,813
General expenses due or accrued	58,821,565	45,408,243
Current federal income tax payable	751,100	4,258,754
Ceded reinsurance premiums payable	175,349	162,450
Remittances and items not allocated	68	438
Amounts due to parent, subsidiaries, and affiliates, net	5,032,641	11,436,936
Liability for amounts held under uninsured plans	58,572	52,913
Total liabilities	467,520,600	441,074,198
CAPITAL AND SURPLUS:		
Section 9010 ACA subsequent fee year assessment	-	43,016,618
Common capital stock, $2 par value — 1,000,000 shares authorized; 900,000 shares issued and outstanding	1,800,000	1,800,000
Gross paid-in and contributed surplus	67,138,440	67,138,440
Unassigned surplus	196,374,024	73,058,852
Total capital and surplus	265,312,464	185,013,910
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 732,833,064	$ 626,088,108

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	2020	2019
REVENUES:		
Net premium income	$ 2,637,682,936	$ 2,342,968,696
Change in reserve for rate credits	(34,507,580)	4,385,743
Total revenues	2,603,175,356	2,347,354,439
UNDERWRITING DEDUCTIONS:		
Hospital and medical:		
Hospital/medical benefits	1,263,294,322	1,193,708,752
Other professional services	18,070,327	22,498,626
Prescription drugs	527,019,911	411,228,861
Full Medicaid pricing pass through	336,061,399	369,529,001
Incentive pool, withhold adjustments, and bonus amounts	16,639,707	15,978,309
Net reinsurance incurred	968,932	657,055
Total hospital and medical	2,162,054,598	2,013,600,604
Claims adjustment expenses	82,594,580	95,129,543
General administrative expenses	249,391,327	210,859,871
Decrease in reserves for accident and health contracts	(23,233,000)	(20,432,000)
Total underwriting deductions	2,470,807,505	2,299,158,018
NET UNDERWRITING GAIN	132,367,851	48,196,421
NET INVESTMENT GAINS:		
Net investment income earned	6,363,631	8,516,496
Net realized capital losses less capital benefit of $61,394 and $15,440 in 2020 and 2019, respectively	(230,960)	(100,047)
Total net investment gains	6,132,671	8,416,449
NET LOSS FROM AGENTS' OR PREMIUM BALANCES CHARGED OFF	(280,259)	(63,492)
NET INCOME BEFORE FEDERAL INCOME TAXES	138,220,263	56,549,378
FEDERAL INCOME TAXES INCURRED	33,166,495	7,633,194
NET INCOME	$ 105,053,768	$ 48,916,184

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF CHANGES IN CAPITAL AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	Section 9010 ACA Subsequent Fee Year Assessment	Common Capital Stock		Gross Paid-In and Contributed Surplus	Unassigned Surplus	Total Capital and Surplus
		Shares	Amount			
BALANCE — January 1, 2019	$ -	900,000	$ 1,800,000	$ 67,138,440	$ 81,309,353	$ 150,247,793
Net income	-	-	-	-	48,916,184	48,916,184
Change in net unrealized capital losses on investments less capital gains benefit of ($71)	-	-	-	-	267	267
Change in net deferred income taxes	-	-	-	-	(1,297,569)	(1,297,569)
Change in nonadmitted assets	-	-	-	-	(12,852,765)	(12,852,765)
Section 9010 ACA subsequent fee year assessment	43,016,618	-	-	-	(43,016,618)	-
BALANCE — December 31, 2019	43,016,618	900,000	1,800,000	67,138,440	73,058,852	185,013,910
Net income	-	-	-	-	105,053,768	105,053,768
Change in net unrealized capital losses on investments less capital gains benefit of ($58)	-	-	-	-	(218)	(218)
Change in net deferred income taxes	-	-	-	-	566,477	566,477
Change in nonadmitted assets	-	-	-	-	(25,321,473)	(25,321,473)
Section 9010 ACA subsequent fee year assessment	(43,016,618)	-	-	-	43,016,618	-
BALANCE — December 31, 2020	$ -	900,000	$ 1,800,000	$ 67,138,440	$ 196,374,024	$ 265,312,464

See notes to statutory basis financial statements.

UNITEDHEALTHCARE OF LOUISIANA, INC.

STATUTORY BASIS STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2020 AND 2019

	2020	2019
CASH FLOWS FROM OPERATIONS:		
Premiums collected, net of reinsurance	$ 2,619,433,941	$ 2,335,729,020
Net investment income	8,665,199	10,640,897
Benefit and loss related payments	(2,170,051,766)	(1,950,089,443)
Commissions and other expenses paid	(318,483,805)	(316,401,361)
Federal income taxes paid, net	(36,612,755)	(22,083,065)
Net cash provided by operations	102,950,814	57,796,048
CASH FLOWS FROM INVESTMENTS:		
Proceeds from investments:		
Bonds sold or matured	27,276,272	77,009,943
Miscellaneous proceeds	(3,310)	338
Total investment proceeds	27,272,962	77,010,281
Cost of investments acquired:		
Bonds	(36,271,591)	(82,083,644)
Other invested assets	(2,436,492)	-
Total cost of investments acquired	(38,708,083)	(82,083,644)
Net cash used in investments	(11,435,121)	(5,073,363)
CASH FLOWS FROM FINANCING AND MISCELLANEOUS ACTIVITIES:		
Cash used in net transfers to affiliates	(6,404,295)	(118,618)
Other cash provided	476	1,589
Net cash used in financing and miscellaneous activities	(6,403,819)	(117,029)
RECONCILIATION OF CASH AND CASH EQUIVALENTS:		
NET CHANGE IN CASH AND CASH EQUIVALENTS	85,111,874	52,605,656
CASH AND CASH EQUIVALENTS — Beginning of year	177,638,046	125,032,390
CASH AND CASH EQUIVALENTS — End of year	$ 262,749,920	$ 177,638,046

See notes to statutory basis financial statements.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND GOING CONCERN

Organization and Operation

UnitedHealthcare of Louisiana, Inc. (the "Company"), licensed as a health maintenance organization ("HMO"), offers its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. ("UHC"). UHC is a wholly owned subsidiary of 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 April 9, 1986, as an HMO and operations commenced in November 1986. The Company is certified as an HMO, by the Louisiana Department of Insurance ("LADOI").The Company has entered into contracts with physicians, hospitals, and other health care provider organizations to deliver health care services for all enrollees.

The Company offers comprehensive commercial products to employer groups. Each contract outlines the coverage provided and renewal provisions.

The Company served as a plan sponsor offering Medicare Parts A & B, along with Medicare Part D prescription drug insurance coverage (collectively "Medicare program") under a contract with the Centers for Medicare and Medicaid Services ("CMS"). The Company receives seven different payment elements either during the year or at final settlement in the subsequent year: 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"). The applicable payment elements are received either during the year or at settlement in the subsequent year. Each component of the Medicare program is further defined throughout Note 1. Effective January 1, 2020, the Company has elected not to participate as a sponsor of the Medicare program in the State of Louisiana.

The Company has a contract with the State of Louisiana, Louisiana Department of Health ("LDH"), to provide health care services to Healthy Louisiana (a program for uninsured adults and children) eligible beneficiaries in Louisiana. The current contract is effective through December 31, 2021.

A. Accounting Practices

The statutory basis financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the LADOI.

The LADOI recognizes only statutory accounting practices, prescribed or permitted by the State of Louisiana, for determining and reporting the financial condition and results of operations of an HMO, for determining its solvency under Louisiana 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 or permitted by the State of Louisiana and the NAIC SAP which materially affect the statutory basis net income and capital and surplus, as illustrated in the table below:

	SSAP #	AFS Line Desc	December 31, 2020	December 31, 2019
Net Income				
(1) Company state basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	$ 105,053,768	$ 48,916,184
(2) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(3) State permitted practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	$ 105,053,768	$ 48,916,184
Capital and Surplus				
(5) Company state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	$ 265,312,464	$ 185,013,910
(6) State prescribed practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(7) State permitted practices that are an increase/(decrease) from NAIC SAP: Not Applicable			-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	$ 265,312,464	$ 185,013,910

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 hospital and medical benefits, claims unpaid, aggregate health policy reserves (including medical loss ratio rebates and premium deficiency reserves ("PDR")), aggregate health claim reserves, 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 or permitted by the LADOI. 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 are stated at book/adjusted carrying value if they meet NAIC designation of one or two and stated at the lower of book/adjusted carrying value or fair value if they meet an NAIC designation of three or higher. The Company does not have any mandatory convertible securities or Securities Valuation Office of the NAIC ("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 are valued and reported using market prices published by the SVO in accordance with the NAIC Valuation of Securities manual prepared by the SVO or an external pricing service;

(3–4) The Company holds no common or preferred stock;

(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 holds no investments in subsidiaries, controlled, or affiliated entities;

(8) The Company has no investment interests with respect to joint ventures, partnerships, or limited liability companies;

(9) The Company holds no derivatives;

(10) PDR (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 health policy reserves 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 data and assumptions underlying such estimates and the resulting reserves are periodically updated, and any adjustments are reflected as a decrease in reserves for accident and health contracts in the statutory basis statements of operations in the period in which the change in estimate is identified. The Company does anticipate investment income as a factor in the PDR 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. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and general administrative expenses ("GAE") to be reported in the statutory basis statements of operations. 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 unpaid CAE 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, 2020 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) The Company does not carry any fixed assets in the statutory basis financial statements;

(13) Health care receivables 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 receivables also include receivables for amounts due to the Company for claim overpayments to providers, hospitals and other health care organizations. Health care receivables 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

- The Company holds no short-term investments;
- 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;
- Cash and cash equivalents 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 operating accounts. Claims and other payments are made from the operating accounts daily;
- 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. Cash equivalents have original maturity dates of three months or less from the date of acquisition. Money-market funds are reported at fair value or net asset value ("NAV") as a practical expedient;
- Realized capital gains and losses on sales of investments are calculated based upon specific identification of the investments sold. These gains and losses are reported as net realized capital losses less capital gains benefit ("net realized capital gains (losses) less taxes") in the statutory basis statements of operations;

- 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 (losses) less taxes 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 an other-than-temporary impairment ("OTTI") of $555,076 and $0 for the years ended December 31, 2020 and 2019, respectively;

- The NAIC SAP requires the following captions to be taken into consideration in the reconciliation of the statutory basis statements of cash flows: cash, including cash overdrafts, cash equivalents, and short-term investments, which can include restricted cash reserves, with original maturities of one year or less from the time of acquisition, whereas under GAAP, pursuant to Accounting Standards Update 2016-18*, Statement of Cash Flows, Restricted Cash,* the statements of cash flows reconcile the corresponding captions of cash, cash equivalents and restricted cash 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 NAIC SAP. 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 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 groups, CMS, and state Medicaid agency 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 (see Note 24):

  a) commercial risk adjustment receivables as defined in Section 1343 of the Affordable Care Act ("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. The risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. 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 corridor receivables for which adjustments are based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare Plan varies more than 5% above the level estimated in the original bid submitted by the Company and approved by CMS;

c) CMS risk adjustment receivables for the Medicare Plans. The risk adjustment model apportions premiums paid to all health 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;

d) premium withhold receivables from LDH which are calculated as a percentage of the capitation rate based on the Company's estimate of performance metrics that have been met as of the financial statement date; and

e) Hepatitis C risk corridor receivables from LDH for which adjustments are based on whether the Company's actual loss ratios are in excess of minimal loss ratio requirements based on plan variances from the original estimated capitation rates.

Premium adjustments for the CMS and Medicaid risk corridor programs are accounted for as premium adjustments subject to retrospectively rated features. Premium adjustments for the commercial ACA Section 1343 risk adjustment, CMS risk adjustment, and Medicaid performance program are accounted for as premium adjustments subject to redetermination.

- **Amounts Receivable Relating to Uninsured Plans** — The Company reports amounts due to the Company from CMS for the administrative activities it performs for which it has no insurance risk as amounts receivable relating to uninsured plans (see Note 18). Amounts receivable relating to uninsured plans include the following:

  a) costs incurred in excess of the cost reimbursement under the Medicare Plans 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; and

  b) the ACA mandates consumer discounts of 70% 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. The Company solely administers the application of these funds and has no insurance risk.

- **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.

LIABILITIES

- **Claims Unpaid and Aggregate Health Claim Reserves** — Claims unpaid and aggregate health claim reserves include 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, and payments and liabilities for physician, hospital, and other medical costs disputes.

  The estimates for incurred but not yet reported claims are developed using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates such liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. These 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 2020 and 2019. Management believes the amount of claims unpaid and aggregate health claim reserves is a best estimate of the Company's liability for unpaid claims and aggregate health claim reserves as of December 31, 2020; however, actual payments may differ from those established estimates.

  The reserves ceded to reinsurers for claims unpaid and aggregate health claim reserves have been reported as reductions of the related reserves rather than as assets, which would be required under GAAP.

  The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

  The Company has a contract with the LDH in which the Company processes Full Medicaid Pricing ("FMP") payments to specified providers where the FMP has agreements. The Company records both the amounts collected from the LDH and the amounts disbursed to providers, excluding FMP related premium tax, as net premium income and hospital and medical expense, respectively, in the statutory basis statements of operations. Unsettled FMP payments owed to providers, net of premium tax, of $151,676,494 and $167,688,518 is included in claims unpaid as of December 31, 2020 and 2019, respectively, in the statutory basis statements of admitted assets, liabilities and capital and surplus.

- **Accrued Medical Incentive Pool and Bonus Amounts** — 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 accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus. The Company also 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 accrued medical incentive pool and bonus amounts in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

- **Aggregate Health Policy Reserves** — Aggregate health policy reserves includes:

  a) commercial 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. The risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. 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, The data used by CMS to determine the risk adjustment amount is subject to risk adjustment data validation audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded (see Note 24);

  b) CMS risk adjustment payables for the Medicare Plans. The risk adjustment model apportions premiums paid to all health plans according to the health severity and certain demographic factors of its Medicare Plans 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. If diagnosis data submitted to CMS needs to be corrected or deleted, the revised diagnosis data can be re-submitted. The Company estimates reductions to risk adjustment revenues and corresponding change in CMS risk adjustment payables 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 (see Note 24);

  c) estimated rebates payable on the comprehensive commercial, Medicaid and Medicare Plans, if the medical loss ratios on these fully insured products, as calculated under the definitions of the ACA and/or State statutes and implementing regulations, fall below certain targets. The Company is required to rebate the ratable portions of the premiums annually (see Note 24);

  d) risk corridor payables due to LDH for which adjustments are based on whether the Company incurs benefit costs that are less than 98% of the target amount for the products subject to the corridor; (see Note 24); and

e) the estimated amount for PDR (see Note 30).

- **Premiums Received in Advance** — Premiums received in full for the policies processed during the current period, but prior to the commencement of the service period, are recorded as premiums received in advance in the statutory basis statements 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. General expenses due or accrued also include the amounts for unpaid assessments, premium taxes, and the unpaid portion of the contributions required under the ACA risk adjustment program (see Note 24).

- **Current Federal Income Tax 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).

- **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.

- **Amounts Due 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 amounts due from the Company to CMS for the administrative activities it performs for which it has no insurance risk (see Note 18). Liabilities for amounts held under uninsured plans includes the ACA mandates consumer discounts of 70% 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. The Company solely administers the application of these funds and has no insurance risk.

CAPITAL AND SURPLUS AND MINIMUM STATUTORY REQUIREMENTS

- **Nonadmitted Assets** — Certain assets, including certain aged premium receivables, certain health care receivables and prepaid expenses, 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 $1,000,000 as of December 31, 2020 and 2019, respectively, in compliance with the State of Louisiana requirements for qualification purposes as a domestic insurer. These restricted

cash reserves consist principally of industrial and miscellaneous bonds and are stated at book/adjusted carrying value, which approximates fair value. These restricted deposits are included in bonds 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 Louisiana, the LADOI 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 managed care organization to support its overall business operations in consideration of its size and risk profile. The LADOI 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 has $265,312,464 and $185,013,910 in total statutory basis capital and surplus as of December 31, 2020 and 2019, 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, as of December, 31, 2019, an amount equal to the estimated subsequent year fee was 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 2021 Health Insurer Fee ("HIF") repeal, no HIF will be payable in 2021 or thereafter, therefore no amounts will be apportioned out of unassigned surplus after December 31, 2019.

STATEMENTS OF OPERATIONS

- **Net Premium Income and Change in Reserve for Rate Credits** — Revenues consist of net premium income that is recognized in the period in which enrollees are entitled to receive health care services. Net premium income is 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 a change in reserve for rate credits in the statutory basis statements of operations. Under GAAP, the change in unearned premium from year to year 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 change in reserve for rate credits 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 commercial risk corridor and commercial risk adjustment balances which are reflected in change in reserve for rate credits and net premium income, respectively, in the statutory basis statements of operations (see Note 24).

  Net premium income includes premiums under the Medicare Plans which includes CMS premiums, including amounts pursuant to the CMS risk adjustment program, member premiums, and the CMS low-income premium subsidy for the Company's insurance risk

coverage. Net premium is recognized ratably over the period in which eligible individuals are entitled to receive health care services and prescription drug benefits.

Company also records estimates related to the CMS Medicare risk corridor program. Changes to these estimates are reflected as change in reserve for rate credits in the statutory basis statements of operations.

The Company's Medicare 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 change in reserve for rate credits in the statutory basis statements of operations.

Net premium income 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 the Medicaid Program. 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. Included in net premium income are capitated payments, home nursing risk-sharing payments, high-dollar risk pool payments, and maternity payments. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled. Home nursing risk-sharing income is payable based upon the number of members that qualify for such reimbursement.

The Medicaid plan is subject to experience rebates, risk adjustments, and performance guarantees based on various utilization measures. The Company has reported its estimated risk adjustments and experience rebates as a component of net premium income and change in reserve for rate credits, respectively, in the statutory basis statements of operations.

- **Full Medicaid Pricing Pass Through Program** — The LDH and the Company entered into a contract in which the Company processes FMP payments to specified providers where the FMP has agreements. Once received from the LDH, the Company disburses funds from an allocated pool to hospitals, physician groups, and ambulance groups, less any premium taxes. The funds that have been received cannot be directly linked to a specific claim. Additionally, the Company has no obligation to pay the specified providers until funds have been received. The amounts collected, net of tax, are included in net premium income in the statutory basis statements of operations whereas under GAAP, this program is presented on a net basis as general administrative expenses. FMP receipts of $345,728,446 and $369,529,001 were recorded to net premium income as of December 31, 2020 and 2019 respectively.

- **Total Hospital and Medical Expenses** — Total hospital and medical expenses 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, and payments and liabilities for physician, hospital, and other medical costs disputes.

  Total hospital and medical expenses also include amounts incurred for incentive pool, withhold adjustments, and bonus amounts that are based on the underlying contractual provisions with the respective providers. In addition, adjustments to claims unpaid estimates and aggregate health claim reserves are reflected in the period once the change in estimate is identified and included in total hospital and medical expenses in the statutory basis statements of operations.

- **General Administrative 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. Premium taxes are also a component of GAE. A detailed review of the administrative expenses of the Company and UHS is performed to determine the allocation between CAE and GAE to be reported in the statutory basis statements of operations.

  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 during the calendar year, which is nondeductible for tax purposes (see Note 22). Under the NAIC SAP, the entire amount of the estimated annual fee expense is recognized on January 1 of the fee year in GAE 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.

- **Net Investment Income Earned** — Net investment income earned 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 earned (see Note 7).

- **Federal Income Taxes Incurred** — The provision for federal income taxes incurred calculated based on applying the statutory federal income tax rate of 21% to net income before federal income taxes and net realized capital losses 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** — The Company has an insolvency-only reinsurance agreement with UnitedHealthcare Insurance Company ("UHIC"), an affiliate whereby 0.01% of net premium income is ceded to UHIC (see Note 23).

- **Ceded Reinsurance Premiums Payable** — The ceded reinsurance premiums payable balance represents amounts due to the reinsurers for specified coverage which will be paid based on the contract terms.

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 no commercial customers that individually exceed 10% of total direct premiums written and premiums and considerations, including receivables for contracts subject to redetermination, for the years ended December 31, 2020 and 2019.

  Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from members and CMS related to the Medicare Plans as a

percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are less than 1% as of December 31, 2019.

Direct premiums written and uncollected premiums, including receivables for contracts subject to redetermination, from the State of Louisiana, LDH as a percentage of total direct premiums written and total uncollected premiums, including receivables for contracts subject to redetermination, are approximately 100% as of December 31, 2020 and approximately 100% as of December 31, 2019, respectively.

Recently Issued Accounting Standards — The Company reviewed all recently issued guidance in 2020 and 2019 that has been adopted for 2020 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 CORRECTIONS OF ERRORS

No changes in accounting principles or corrections of errors have been recorded during the years ended December 31, 2020 and 2019.

3. BUSINESS COMBINATIONS AND GOODWILL

A–D. The Company was not party to a business combination during the years ended December 31, 2020 and 2019, 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 2020 and 2019.

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

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 $326,203 and $60,448, respectively, for 2020 and $163,114 and $278,601, respectively, for 2019. There were no gross realized gains and losses on sales of short-term investments for 2020 and 2019. The net realized loss is included in net realized capital gains (losses) less taxes in the statutory basis statements of operations. Total proceeds on the sale of long-term investments were $7,150,976 and $63,974,963. There were no proceeds on the sales of short-term investments in 2020 and 2019.

As of December 31, 2020 and 2019, the book/adjusted carrying value, fair value, and gross unrecognized unrealized gains and losses of the Company's investments, excluding cash and cash equivalents of $262,749,920 and $177,638,046 respectively, are disclosed in the table below.

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 41,733,929	$ 2,848,156	$ 53,613	$ -	$ 44,528,472
State and agency municipal securities	26,300,405	1,848,179	-	-	28,148,584
City and county municipal securities	50,631,241	3,317,107	-	-	53,948,348
Corporate debt securities	122,760,456	8,431,641	9,365	-	131,182,732
Other invested assets	2,434,863	0	-	-	2,434,863
Total bonds and other invested assets	$ 243,860,894	$ 16,445,083	$ 62,978	$ -	$ 260,242,999

	2020				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
Less than one year	$ 9,309,278	$ 56,799	$ -	$ -	$ 9,366,077
One to five years	107,810,371	5,388,925	882	-	113,198,414
Five to ten years	80,809,110	8,283,812	53,613	-	89,039,309
Over ten years	45,932,135	2,715,547	8,483	-	48,639,199
Total bonds and other invested assets	$ 243,860,894	$ 16,445,083	$ 62,978	$ -	$ 260,242,999

	2019				
	Book/Adjusted Carrying Value	Gross Unrecognized Unrealized Gains	Gross Unrecognized Unrealized Losses < 1 Year	Gross Unrecognized Unrealized Losses > 1 Year	Fair Value
U.S. government and agency securities	$ 42,228,395	$ 1,362,226	$ 4,666	$ 50,190	$ 43,535,765
State and agency municipal securities	24,580,972	1,018,193	833	-	25,598,332
City and county municipal securities	49,751,344	1,818,467	-	-	51,569,811
Corporate debt securities	118,253,362	3,287,318	62,379	6,740	121,471,561
Total bonds	$ 234,814,073	$ 7,486,204	$ 67,878	$ 56,930	$ 242,175,469

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 $29,205,446 and fair value of $30,633,918.

The following table illustrates the fair value and gross unrecognized unrealized losses, aggregated by investment category and length of time that the individual securities have been in a continuous unrecognized unrealized loss position as of December 31, 2020 and 2019:

	2020					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 3,787,389	$ 53,613	$ -	$ -	$ 3,787,389	$ 53,613
Corporate debt securities	2,711,820	9,365	-	-	2,711,820	9,365
Total bonds	$ 6,499,209	$ 62,978	$ -	$ -	$ 6,499,209	$ 62,978

	2019					
	< 1 Year		> 1 Year		Total	
	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses	Fair Value	Gross Unrecognized Unrealized Losses
U.S. government and agency securities	$ 1,471,061	$ 4,666	$ 6,224,024	$ 50,190	$ 7,695,085	$ 54,856
State and agency municipal securities	829,844	833	-	-	829,844	833
Corporate debt securities	10,002,349	62,379	1,121,687	6,740	11,124,036	69,119
Total bonds	$ 12,303,254	$ 67,878	$ 7,345,711	$ 56,930	$ 19,648,965	$ 124,808

The unrecognized unrealized losses on investments in U.S. government and agency securities, state and agency municipal securities, and corporate debt securities at December 31, 2020 and 2019, were mainly caused by interest rate fluctuations 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 assessed the credit quality of the state and agency municipal securities, city and county municipal securities 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 an OTTI of $555,076 and $0 as of December 31, 2020 and 2019, respectively, which are included in net realized capital gains (losses) less taxes in the statutory basis statements of operations.

A–C. The Company has no mortgage loans, real estate loans, restructured debt, or reverse mortgages. The Company also has no real estate property occupied by the Company, 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 (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.

(2) As of December 31, 2020, the Company has classified loan-backed securities that have OTTIs 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, 2020. The table below illustrates the aggregate OTTIs recognized on loan-backed securities classified on the basis for the OTTI during 2020:

	1 Amortized Cost Basis Before Other-than-Temporary Impairment	2 Other-than-Temporary Impairment Recognized in Loss	3 Fair Value 1 - 2
OTTI Recognized 1st Quarter			
a. Intent to sell	$ -	$ -	$ -
b. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
c. Total 1st Quarter	$ -	$ -	$ -
OTTI Recognized 2nd Quarter			
d. Intent to sell	$ 2,117,239	$ 69,680	$ 2,047,559
e. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
f. Total 2nd Quarter	$ 2,117,239	$ 69,680	$ 2,047,559
OTTI Recognized 3rd Quarter			
g. Intent to sell	$ -	$ -	$ -
h. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
i. Total 3rd Quarter	$ -	$ -	$ -
OTTI Recognized 4th Quarter			
j. Intent to sell	$ -	$ -	$ -
k. Inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis	-	-	-
l. Total 4th Quarter	$ -	$ -	$ -
m. Annual aggregate total		$ 69,680	

The Company did not recognize any OTTIs on loan-backed securities due to an inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis, or where the present value of cash flows expected to be collected is less than the amortized cost basis of the security, as of December 31, 2020.

(3) The table below represents the loan-backed securities with an OTTI for the years ended December 31, 2020 and 2019, presented by CUSIP:

2020						
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
00432CBN0	$ 232,929	$ 223,784	$ 9,145	$ 223,784	$ 223,784	6/30/2020
26828WAA2	351,853	340,534	11,319	340,534	340,534	6/30/2020
64032KAA1	1,171,357	1,135,631	35,726	1,135,631	1,135,631	6/30/2020
64033GAA9	68,564	66,196	2,368	66,196	66,196	6/30/2020
69339QAA7	292,536	281,413	11,122	281,413	281,413	6/30/2020
Total	XXX	XXX	$ 69,680	XXX	XXX	XXX

2019						
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
	$ -	$ -	$ -	$ -	$ -	
Total	XXX	XXX	$ -	XXX	XXX	XXX

(4) The following table illustrates the fair value, gross unrecognized unrealized losses, and length of time that the loan-backed securities have been in a continuous unrecognized unrealized loss position as of December 31, 2020 and 2019:

	2020
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ -
2. 12 months or longer	-
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	-
2. 12 months or longer	-

	2019
The aggregate amount of unrealized losses:	
1. Less than 12 months	$ 43,019
2. 12 months or longer	54,990
The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 months	5,382,753
2. 12 months or longer	6,547,982

(5) The Company believes that it will continue to collect timely the principal and interest due on its loan-backed securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate changes and not by unfavorable

changes in the credit quality associated with these securities that impacted the assessment on collectability of principle and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers, and the potential economic impacts of COVID-19 on the issuers, noting no significant credit deterioration since purchase. As of December 31, 2020, the unrealized loss on any security that the Company classified as intent to sell was not material to the Company's investment portfolio. Any other securities in an unrealized loss position as of December 31, 2020, the Company considers to be temporary.

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. Low-Income Housing Tax Credits

(1–7) LIHTC investments of $2,434,863 and $0 as of December 31, 2020 and 2019, 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 $3,983,776 and $0 as of December 31, 2020 and 2019, 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 12 years and the required holding period for the LIHTC investments is 16 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 2020 or 2019.

L. Restricted Assets

(1) Restricted assets, including pledged securities as of December 31, 2020 and 2019, are presented below:

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/ (Decrease) (1 Minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
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	1,000,000	1,000,000	-	-	1,000,000	-	-
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	$ 1,000,000	$ 1,000,000	$ -	$ -	$ 1,000,000	- %	- %

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 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, 2020 or 2019.

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. 5GI Securities

The Company does not have any investments with an NAIC designation of 5GI as of December 31, 2020 and 2019.

P. Short Sales — Not applicable.

Q. Prepayment Penalty and Acceleration Fees —

The following table illustrates prepayment penalty and acceleration fees as of December 31, 2020:

	General Account
1. Number of CUSIPs	4
2. Aggregate Amount of Investment Income	$ 88,370

R. Reporting Entity's Share of Cash Pool by Asset Type — 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–B. 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, 2020 and 2019 are as follows:

	2020			2019			Change		
	1 Ordinary	2 Capital	3 (Col 1 + 2) Total	4 Ordinary	5 Capital	6 (Col 4 + 5) Total	7 (Col 1 - 4) Ordinary	8 (Col 2 - 5) Capital	9 (Col 7 + 8) Total
(a) Gross deferred tax assets	$ 14,081,007	$ -	$ 14,081,007	$ 13,585,830	$ 13	$ 13,585,843	$ 495,177	$ (13)	$ 495,164
(b) Statutory valuation allowance adjustments	-	-	-	-	-	-	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	14,081,007	-	14,081,007	13,585,830	13	13,585,843	495,177	(13)	495,164
(d) Deferred tax assets nonadmitted	-	-	-	-	-	-	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	14,081,007	-	14,081,007	13,585,830	13	13,585,843	495,177	(13)	495,164
(f) Deferred tax liabilities	220,662	-	220,662	288,750	3,283	292,033	(68,088)	(3,283)	(71,371)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	$ 13,860,345	$ -	$ 13,860,345	$ 13,297,080	$ (3,270)	$ 13,293,810	$ 563,265	$ 3,270	$ 566,535

(2) The components of the adjusted gross deferred tax assets admissibility calculation under Statement of Statutory Accounting Principles ("SSAP") No. 101, *Income Taxes*, are as follows:

	2020			2019			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	$ 14,081,007	$ -	$ 14,081,007	$ 13,585,830	$ -	$ 13,585,830	$ 495,177	$ -	$ 495,177
(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)	-	-	-	-	-	-	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-	-	-	-	-	-	-
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	37,717,818	XXX	XXX	17,172,010	XXX	XXX	20,545,808
(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	-	-	-	-	13	13	-	(13)	(13)
(d) Deferred tax assets admitted as the result of application of SSAP No. 101 Total (2(a) + 2(b) + 2(c))	$ 14,081,007	$ -	$ 14,081,007	$ 13,585,830	$ 13	$ 13,585,843	$ 495,177	$ (13)	$ 495,164

(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:

	2020	2019
(a) Ratio percentage used to determine recovery period and threshold limitation amount	379 %	249 %
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)(2) above	$ 251,452,119	$ 171,720,100

(4) The impact to the gross deferred tax assets balances as a result of tax-planning strategies as of December 31, 2020 and 2019 is presented below:

	2020		2019		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)	$ 14,081,007	$ -	$ 13,585,830	$ 13	$ 495,177	$ (13)
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)	$ 14,081,007	$ -	$ 13,585,830	$ 13	$ 495,177	$ (13)
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, 2020 and 2019.

C. Significant Components of Income Taxes

(1) The current federal income taxes incurred for the years ended December 31, 2020 and 2019 are as follows:

	1	2	3
	2020	2019	(Col 1 - 2) Change
1. Current income tax			
(a) Federal	$ 33,166,495	$ 7,633,194	$ 25,533,301
(b) Foreign	-	-	-
(c) Subtotal	33,166,495	7,633,194	25,533,301
(d) Federal income tax on net capital gains (losses)	(61,394)	(15,440)	(45,954)
(e) Utilization of capital loss carryforwards	-	-	-
(f) Other	-	-	-
(g) Total federal and foreign income taxes incurred (benefit)	$ 33,105,101	$ 7,617,754	$ 25,487,347

(2–4) The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities as of December 31, 2020 and 2019, are as follows:

	1 2020	2 2019	3 (Col 1 - 2) Change
2 Deferred tax assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$ 1,071,861	$ 1,022,393	$ 49,468
(2) Unearned premium reserve	13,448	5,956	7,492
(3) Policyholder reserves	-	4,878,930	(4,878,930)
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables — nonadmitted	12,995,667	7,678,158	5,317,509
(11) Net operating loss carryforw ard	-	-	-
(12) Tax credit carryforw ard	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	31	393	(362)
(99) Subtotal	14,081,007	13,585,830	495,177
(b) Statutory valuation allow ance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	14,081,007	13,585,830	495,177
(e) Capital:			
(1) Investments	-	-	-
(2) Net capital loss carryforw ard	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	13	(13)
(99) Subtotal	-	13	(13)
(f) Statutory valuation allow ance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	13	(13)
(i) Admitted deferred tax assets (2d + 2h)	14,081,007	13,585,843	495,164
3 Deferred tax liabilities:			
(a) Ordinary:			
(1) Investments	-	23,956	(23,956)
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	220,662	264,794	(44,132)
(99) Subtotal	220,662	288,750	(68,088)
(b) Capital:			
(1) Investments	-	3,212	(3,212)
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	71	(71)
(99) Subtotal	-	3,283	(3,283)
(c) Deferred tax liabilities (3a99 + 3b99)	220,662	292,033	(71,371)
4 Net deferred tax assets/liabilities (2i - 3c)	$ 13,860,345	$ 13,293,810	$ 566,535

The other ordinary deferred tax liability of $220,662 for 2020 and $264,794 for 2019 consists of discounting of unpaid losses. The other capital deferred tax asset of $13 for 2019 consists of unrealized losses.

The Company assessed the potential realization of the gross deferred tax asset and as a result no statutory valuation allowance was required and no allowance was established as of December 31, 2020 and 2019.

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 21% to net income before federal income taxes incurred, less capital gains (benefit). A summarization of the significant items causing this difference as of December 31, 2020 and 2019 is as follows:

	2020		2019	
	Amount	Effective Tax Rate	Amount	Effective Tax Rate
Tax provision at the federal statutory rate	$ 29,013,362	21 %	$ 11,872,127	21 %
Tax-exempt interest	(241,672)	-	(257,722)	(1)
Health insurer fee	9,084,443	6	-	-
Tax effect of nonadmitted assets	(5,317,509)	(4)	(2,699,082)	(5)
Prior year true-up	(1,183,980)	(1)	6,716,220	12
Prior year audited financial statement adjustment, net with true-up above	1,183,980	1	(4,789,890)	(8)
Deferred corrections	-	-	(1,926,330)	(3)
Total statutory income taxes	$ 32,538,624	23 %	$ 8,915,323	16 %
Federal income taxes incurred	$ 33,166,495	23 %	$ 7,633,194	14 %
Capital gains tax	(61,394)	-	(15,440)	-
Change in net deferred income tax	(566,477)	-	1,297,569	2
Total statutory income taxes	$ 32,538,624	23 %	$ 8,915,323	16 %

E. At December 31, 2020, the Company had no net operating loss carryforwards.

Current federal income tax payable of $751,100 and $4,258,754 as of December 31, 2020 and 2019, respectively, are included in the statutory basis statements of admitted assets, liabilities, and capital and surplus. Federal income taxes paid, net of refunds were $36,612,755 and $22,083,065 in 2020 and 2019, respectively.

Federal income taxes incurred of $33,105,101 and $7,617,755 for 2020 and 2019, 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 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 through 2020 tax returns are under 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 the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

G. Tax Contingencies — Not applicable.

H. Repatriation Transition Tax — Not applicable.

I. Alternative Minimum Tax Credit — Not applicable.

10. INFORMATION CONCERNING PARENT, SUBSIDIARIES, AND AFFILIATES

A–B. In the ordinary course of business, the Company contracts with several affiliates to provide a wide variety of services to the Company's members. These agreements are filed with and approved by the LADOI according to Management's understanding of the current requirements and standards. Within the confines of the applicable filed and approved agreements (including subsequent amendments thereto), the amount and types of services provided by these affiliated entities can change year over year.

The Company has a tax-sharing agreement with UnitedHealth Group (see Note 9).

The Company holds a $100,000,000 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 credit agreement is enforced unless terminated by either party. No amounts were outstanding under the line of credit as of December 31, 2020 and 2019.

The Company has entered into a reinsurance agreement with an affiliated entity (see Note 23).

C. Transactions With Related Parties Who Are Not Reported On Schedule Y

The Company has no material related party transactions that meet the disclosure requirements pursuant to SSAP No. 25, *Affiliates and Other Related Parties* ("SSAP No. 25") that are not included in NAIC Statutory Statement Schedule Y — Part 2 Summary Of Insurer's Transactions With Any Affiliates.

D. At December 31, 2020 and 2019, the Company reported $5,032,641 and $11,436,936, respectively, as amounts due to parent, subsidiaries and affiliates, 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.

E. The administrative services, access fees, and cost of care services provided by affiliates are calculated using one or more of the following methods: (1) a percentage of premiums; (2) use of assets; (3) direct pass-through of charges; (4) per member per month; (5) per employee per month; (6) per claim; or (7) a combination thereof consistent with the provisions contained in each contract. These amounts are included in GAE, CAE, and total hospital and medical expense in the statutory basis statements of operations. The following table identifies the amounts reported for the administrative services, access fees, and cost of care services provided by related parties

for the years ended December 31, 2020 and 2019, which meet the disclosure requirements pursuant to SSAP No. 25, regardless of the effective date of the contract:

	2020	2019
OptumRx, Inc.	$ 555,229,485	$ 427,129,037
United HealthCare Services, Inc.	112,636,282	127,999,185
United Behavioral Health	27,282,868	26,448,952
OptumInsight, Inc.	3,075,659	3,213,028
AxelaCare Intermediate Holdings, LLC	-	8,787,370

OptumRx provides services that may include, but are not limited to, administrative services related to pharmacy management and pharmacy claims processing for enrollees, manufacturer rebate administration, pharmacy incentive services, specialty drug pharmacy services, durable medical equipment services including orthotics and prosthetics and personal health products catalogues showing the healthcare products and benefit credits enrollees needed to redeem the respective products.

UHS provides, or arranges for the provision of, management, administrative, and other services deemed necessary or appropriate for UHS to provide management and operational support to the Company. The services can include, but are not limited to, the categories of management and operational services outlined in the Agreement, such as human resources, legal, facilities, general administration, treasury and investment functions, claims adjudication and payment, benefit administration, disease management, health care decision support, medical management, credentialing, preventative health services, and utilization management reporting.

United Behavioral Health provides services related to mental health and substance abuse treatment.

OptumInsight, Inc. provides services that may include, but are not limited to, claim analytics and 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.

AxelaCare Intermediate Holdings, LLC provides home infusion therapy services.

The Company has premium payments that are received and claim payments and direct expenses such as broker commissions, LADOI exam fees, ACA assessments and premium taxes that are processed and paid by an affiliated UnitedHealth Group entity. Premiums, claims, and direct expenses applicable to the Company are settled at regular intervals throughout the month via the intercompany settlement process and any amounts outstanding are reflected in amounts due to parent, subsidiaries, and affiliates, net in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

F. The Company has not extended any guarantees or undertakings for the benefit of an affiliate or related party.

G. The Company is part of an insurance holding company system with UnitedHealth Group as the ultimate parent. Management believes that the Company's 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.

H. 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, controlled, or affiliated entity.

I. The Company does not have any investments in a subsidiary, controlled, or affiliated entity that exceeds 10% of admitted assets.

J. The Company does not have any investments in impaired subsidiaries, controlled, or affiliated entities.

K. The Company does not have any investments in foreign insurance subsidiaries.

L. The Company does not hold any investments in a downstream noninsurance holding company.

M. The Company does not have any investments in noninsurance subsidiaries, controlled, or affiliated entities.

N. The Company does not have any investments in insurance subsidiaries, controlled, or affiliated entities.

O. The Company does not have any investments in subsidiary, controlled, or affiliated entities or joint ventures, partnerships and limited liability companies in which the Company's share of losses exceeds the investment.

11. DEBT

A–B. The Company had no outstanding debt with third-parties or outstanding Federal Home Loan Bank agreements during 2020 and 2019.

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, DIVIDEND RESTRICTIONS, AND QUASI-REORGANIZATIONS

A–B. The Company has 1,000,000 shares authorized and 900,000 shares issued and outstanding of $2 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, UHC.

C. Dividend payment requirements are outlined in the domiciliary state statutes and may be further restricted by the LADOI.

D. The Company paid no dividends and no infusions were received during 2020 or 2019.

E. The amount of ordinary dividends that may be paid out during any given period is subject to certain restrictions as specified by state statute.

F. There are no restrictions placed on the Company's unassigned surplus.

G. The Company is not a mutual reciprocal or a similarly organized entity and does not have advances to surplus not repaid.

H. 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.

I. As discussed in Note 1, in 2020 no amount was required to be apportioned out of unassigned surplus as the HIF was repealed by Congress, effective January 1, 2021. For the year ended December 31, 2019, the amount of the estimated Section 9010 ACA subsequent fee year assessment apportioned out of unassigned surplus was $43,016,618.

J. The portion of unassigned surplus, excluding the apportionment of estimated Section 9010 ACA subsequent fee year assessment, and net income, represented (or reduced) by each item below is as follows:

	2020	2019
Unrealized capital (losses) gains on investments	$ -	$ 276
Net deferred income taxes	13,860,345	13,293,810
Nonadmitted assets	(61,884,129)	(36,562,656)
Total	$ (48,023,784)	$ (23,268,570)

K–M. 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 given LIHTC a commitment for additional investment in the form of an equity contribution that will be required as long as the assets are performing based on the agreed upon contractual terms. The Company has the ability to sell its interest in the LIHTC investment prior to the additional contribution being required. The current amount of the commitment for additional investment is not to exceed the aggregate $3,983,776 as of December 31, 2020.

B. Assessments

The Company is not aware of any guaranty fund assessments or premium tax offsets, potential or accrued, that could have a material financial effect on the operations of the entity.

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 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. 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.

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 made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, the DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

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, 2020 and 2019, except as disclosed in Note 5.

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–C. The Company did not participate in any transfer of receivables, financial assets or wash sales.

18. GAIN OR LOSS TO THE REPORTING ENTITY FROM UNINSURED PLANS AND THE UNINSURED PORTION OF PARTIALLY INSURED PLANS

A–B. The Company has no operations from Administrative Services Only Contracts or Administrative Services Contracts in 2020 and 2019.

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract

The Medicare Part D program is a partially insured plan. The Company recorded a receivable of $175,058 and $185,911 at December 31, 2020 and 2019, respectively, for cost reimbursement under the Medicare Part D program for the catastrophic reinsurance and low-income member cost-sharing subsidies. The Company also recorded a receivable of $0 and $31,823 and also a payable of $58,572 and $52,913 at December 31, 2020 and 2019, respectively, for the Medicare Part D CGDP. The receivables and payables are recorded in amounts receivable relating to uninsured plans and liability for amounts held under uninsured plans, respectively, in the statutory basis statements of admitted assets, liabilities and capital and surplus. These Medicare subsidies are described in Note 1, *Amounts Receivable Relating to Uninsured Plans* and *Liability for Amounts Held Under Uninsured Plans.*

The Company participates in administrating payments for the LDH's Managed Care Incentive Program ("MCIP"), which incentivizes hospitals to meet certain individualized metrics. Once a hospital meets these incentives, they are compensated for their efforts in helping the Medicaid populations. There is no risk to the Company as a result of these transactions. The Company has no payables recorded as of December 31, 2020 and 2019, respectively, for the additional pass-through payments to providers. The payments processed for the MCIP were $112,873,131 and $34,269,790 as of December 31, 2020 and 2019, 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 2020 and 2019.

20. FAIR VALUE MEASUREMENTS

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.

The estimated fair values of bonds and cash equivalents (collectively "investment holdings") 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 tables present information about the Company's financial assets that are measured and reported at fair value at December 31, 2020 and 2019, 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, 2020 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	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	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	262,697,267	-	-	-	262,697,267
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 262,697,267	$ -	$ -	$ -	$ 262,697,267
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

Description for Each Class of Asset or Liability	December 31, 2019 (Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	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	-	-	-	-	-
Parent, subsidiaries, and affiliates	-	-	-	-	-
Total common stocks	-	-	-	-	-
Derivative assets:					
Interest rate contracts	-	-	-	-	-
Foreign exchange contracts	-	-	-	-	-
Credit contracts	-	-	-	-	-
Commodity futures contracts	-	-	-	-	-
Commodity forward contracts	-	-	-	-	-
Total derivatives	-	-	-	-	-
Money-market funds	177,592,989	-	-	-	177,592,989
Separate account assets	-	-	-	-	-
Total assets at fair value/NAV	$ 177,592,989	$ -	$ -	$ -	$ 177,592,989
b. Liabilities at fair value:					
Derivative liabilities	$ -	$ -	$ -	$ -	$ -
Total liabilities at fair value	$ -	$ -	$ -	$ -	$ -

(2) The Company does not have any financial assets with a fair value hierarchy of Level 3 that were measured and reported at fair value.

The Company considers its investments in LIHTC investments a Level 3 investment even though no market valuation was required as of December 31, 2020 and 2019. 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. As a result, these investments are recorded and reported at book value of $2,434,863 and $0 as of December 31, 2020 and 2019.

(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, 2020 or 2019.

(4) The framework the Company has established for determining the fair value of the investment holdings is outlined above.

LIHTC Investments — The Company does consider its investments in LIHTC investments as a Level 3 investment even though no market valuation adjustment was required as of December 31, 2020 and 2019, as. 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, 2020, all of these investments are performing in accordance with their original contract terms.

(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, 2020 and 2019 is presented in the table below:

	December 31, 2020						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 44,528,472	$ 41,733,929	$ 15,651,013	$ 28,877,459	$ -	$ -	$ -
State and agency municipal securities	28,148,584	26,300,405	-	28,148,584	-	-	-
City and county municipal securities	53,948,348	50,631,241	-	53,948,348	-	-	-
Corporate debt securities	131,182,732	122,760,456	-	131,182,732	-	-	-
Cash equivalents	262,697,267	262,697,267	262,697,267	-	-	-	-
Other invested assets	2,434,863	2,434,863	-	-	2,434,863	-	-
Total bonds, cash equivalents, and other invested assets	$ 522,940,266	$ 506,558,161	$ 278,348,280	$ 242,157,123	$ 2,434,863	$ -	$ -

	December 31, 2019						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
U.S. government and agency securities	$ 43,535,765	$ 42,228,395	$ 10,931,140	$ 32,604,625	$ -	$ -	$ -
State and agency municipal securities	25,598,332	24,580,972	-	25,598,332	-	-	-
City and county municipal securities	51,569,811	49,751,344	-	51,569,811	-	-	-
Corporate debt securities	121,471,561	118,253,362	-	121,471,561	-	-	-
Cash equivalents	177,592,989	177,592,989	177,592,989	-	-	-	-
Total bonds and cash equivalents	$ 419,768,458	$ 412,407,062	$ 188,524,129	$ 231,244,329	$ -	$ -	$ -

D. Not Practicable to Estimate Fair Value — Not applicable.

E. Investments Measured Using the NAV Practical Expedient — Not applicable.

21. OTHER ITEMS

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate impact on the Company and its statutory basis results of operations, financial condition and cash flows remains uncertain. During the second quarter, the global health system experienced unprecedented levels of care deferral. As the pandemic advanced, access to and demand for care was most constrained from mid-March through April, began to recover in May and June and restored to near normal seasonal levels in the third quarter. Care patterns continued to normalize in the fourth quarter, including COVID-19 treatment and testing costs. The temporary deferral of care experienced in 2020 may cause care patterns to moderately exceed normal baselines in future periods as utilization of health system capacity continues to increase. The Company has taken various measures which could include expanded benefit coverage in areas such as

COVID-19 care and testing, telemedicine, and pharmacy benefits; provided customers assistance in the form of co-pay waivers and premium forgiveness; offered additional enrollment opportunities to those who previously declined employer-sponsored offerings; extended certain premium payment terms for customers experiencing financial hardship; simplified administrative practices; and accelerated payments to care providers, all with the aim of assisting customers, care providers, members and communities in addressing the COVID-19 crisis. Temporary care deferrals impacted the Company's results of operations for the year ended December 31, 2020. The impact of temporary care deferrals was partially offset by COVID-19 related care and testing, the financial assistance provided to customers, rebate requirements and broader economic impacts.

Increased consumer demand for care, potentially even higher acuity care, along with continued COVID-19 care and testing costs may result in increased future medical costs. Disrupted care patterns, as a result of the pandemic, may temporarily affect the ability to obtain complete member health status information, impacting future revenue in businesses utilizing risk adjustment methodologies. The ultimate overall impact is uncertain and dependent on the future pacing and intensity of the pandemic, the duration of policies and initiatives to address COVID-19, and general economic uncertainty.

Throughout 2020, the Company's ultimate parent announced a number of programs to directly support people affected by the COVID-19 pandemic, including a plan to grant premium credits to the Company's fully insured commercial customers. The total amount of premium credits granted through December 31, 2020 of $21,707 has been reflected as a reduction to net premium income in the statutory basis statements of revenue and expenses.

A. Unusual or Infrequent Items

The Company did not encounter any unusual or infrequent items for the years ended December 31, 2020 and 2019.

B. Troubled Debt Restructuring: Debtors

The Company has no troubled debt restructurings as of December 31, 2020 and 2019.

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 2020 and 2019.

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.

(2) The Company has no direct exposure through investments in sub-prime mortgage loans.

(3) The Company has no direct exposure through other investments.

(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, 2020, the Company is not aware of any possible proceeds of insurance-linked securities.

I. The Amount That Could Be Realized on Life Insurance Where the Reporting Entity is Owner and Beneficiary or Has Otherwise Obtained Rights to Control the Policy — Not applicable.

22. EVENTS SUBSEQUENT

Subsequent events have been evaluated through April 16, 2021, which is the date these statutory basis financial statements were available for issuance.

TYPE I — Recognized Subsequent Events

Any material Type I events subsequent to December 31, 2020, have been recognized in the statutory basis financial statements and corresponding disclosures.

TYPE II — Non-Recognized Subsequent Events

For the years ended December 31, 2020 and 2019, the Company was subject to the annual fee under Section 9010 of the ACA. The 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. The HIF was repealed by Congress, effective January 1, 2021.

The table below presents information regarding the annual fee under Section 9010 of the ACA as of December 31, 2020 and 2019:

	2020	2019
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	$ -	$ 43,016,618
C. ACA fee assessment paid	43,259,252	-
D. Premium written subject to ACA 9010 assessment	-	2,255,081,823
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	265,312,464	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	265,312,464	
G. Authorized Control Level (Five-Year Historical Line 15)	66,317,250	
H. Would reporting the ACA assessment as of December 31, 2020, have triggered an RBC action level (Yes/No)?	No	

There are no other material non-recognized Type II events 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 reinsurers. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company has an insolvency-only reinsurance agreement with UHIC. The Company remains primarily liable as the direct insurer on all risks reinsured.

The Company also had a reinsurance agreement with Unimerica Insurance Company to cede obligations related to chiropractic and physical therapy coverage, transplant coverage, infertility treatment coverage, and mental health and substance use disorder coverage. The reinsurance agreement was terminated effective December 31, 2017.

The Company does not have any unaffiliated reinsurance agreements in place as of December 31, 2020 or 2019.

Pursuant to Section 1341 of the ACA, through 2017, the Company was subject to the reinsurance provisions for compliant individual policies (see Note 24).

The effect of both internal and external reinsurance agreements outlined above on net premium income and hospital and medical expenses is presented below:

	2020	2019
Premiums:		
Direct	$ 2,639,932,995	$ 2,344,955,006
Ceded:		
Affiliate	2,250,059	1,986,310
Net premium income	$ 2,637,682,936	$ 2,342,968,696
Hospital and medical expenses:		
Direct	$ 2,161,085,666	$ 2,012,943,549
Ceded:		
Affiliate	(968,932)	(693,240)
Nonaffiliate	-	36,185
Net hospital and medical expenses	$ 2,162,054,598	$ 2,013,600,604

The Company recognized reinsurance recoveries related to internal and external reinsurance agreements of $(968,932) and $(657,055) in 2020 and 2019, respectively, which are recorded as net reinsurance incurred in the statutory basis statements of operations. In addition $(108,045) and $(1,245) for unpaid losses are recorded as a reduction to claims unpaid in 2020 and 2019, 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 ( ) No (X)

(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, 2020.

(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 2020 and 2019, there were no uncollectible reinsurance recoverables.

C. **Commutation of Ceded Reinsurance** — There was no commutation of reinsurance in 2020 or 2019.

D. **Certified Reinsurer Rating Downgraded or Status Subject to Revocation** — Not applicable.

E. **Reinsurance Credit**

(1) The Company has no reinsurance contracts subject to Appendix A-791 — *Life and Health Reinsurance Agreements* ("A-791") that includes a provision which limits the reinsurer's assumption of significant risk.

(2) The Company has no reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which include a provision that limits the reinsurer's assumption of risk.

(3) The Company's reinsurance contracts do not contain features which result in delays in payment in form or in fact.

(4) The Company has not reflected a reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R, Life, Deposit-Type, and Accident and Health Reinsurance ("SSAP No. 61R").

(5) The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

(6) The Company's ceded reinsurance contract which is not subject to A-791 and not yearly renewable term reinsurance, is treated the same for GAAP and statutory accounting principles.

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 (from) the Company are recorded in premiums and considerations and aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus and as an adjustment to change in reserve for rate credits 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 and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by the ACA. The total amount of direct premiums written for the commercial lines of business for which a portion is subject to the retrospectively rated and redetermination features was $6,685,544 and $2,828,201, representing 0.3% and 0.1% of total direct premiums written as of December 31, 2020 and December 31, 2019, 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 and redetermination features for premium adjustments for changes to each member's health scores based on guidelines determined by CMS. The formula is calculated pursuant to the ACA guidance. The total amount of direct premiums written for the Medicare line of business for which a portion is subject to the retrospectively rated and redetermination features was $(17,461) and $9,355,681, representing less than 0.0% and 0.4% of total direct premiums written as of December 31, 2020 and December 31, 2019, 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 $553,351, representing 0.1% of total direct premiums written as of December 31, 2019.

CMS released the final Medicaid Managed Care Rule which is subject to each State's administration elections. This rule is the first major update to the Medicaid Managed Care regulations in more than a decade, which includes a minimum loss ratio requirement. Pursuant to the regulations, premiums associated with the Company's Medicaid line of business is subject to retrospectively rated features based on the actual medical loss ratios experienced on this product. The calculation is pursuant to the Medicaid Managed Care guidance. In addition, the Company's Medicaid contract with the State is subject to retrospectively rated features under the Hepatitis C risk corridor program for which a portion of total direct premiums written is at risk. In addition, the Company's Medicaid contract with the State is subject to redetermination features for which a portion of the direct premiums written is subject to risk adjusted rating changes and for which a portion of total direct premiums written can be eligible for a performance guarantee payment base on various quality measures. The total amount of direct premiums written for the Medicaid line of business for which a portion is subject to the retrospectively rated and redetermination features was $2,633,264,912 and $2,332,771,124, representing 99.7% and 99.5% of total direct premiums written as of December 31, 2020 and December 31, 2019, respectively.

Effective January 1, 2020, the Company's Medicaid contract with the State includes retrospectively rated features related to the COVID-19 risk corridor program. The Company has

estimated accrued retrospective premiums pursuant to the contract. The total amount of direct premiums written for the Medicaid line of business for which a portion is subject to the retrospectively rated features was $2,633,264,912, representing 99.7% of total direct premiums written as of December 31, 2020.

D. The Company is required to maintain specific minimum loss ratios on the comprehensive commercial and Medicare lines of business.

The Company's actual loss ratios on the comprehensive commercial and Medicare lines of business were in excess of the minimum requirements and as a result, no minimum medical loss ratio rebate liability was required to be established at December 31, 2020 and 2019.

Pursuant to the Medicaid Managed Care Rule, based on the State's election and state contractual minimum loss ratio requirements, the Company is required to maintain specific minimum loss ratios on its Healthy Louisiana and Healthy Louisiana populations. The Company has estimated $0 and $36,273,605 in estimated Medicaid Managed Care Rule and state minimum loss ratio rebates on its Medicaid, Healthy Louisiana, and Healthy Louisiana population as of December 31, 2020 and December 31, 2019, respectively, which is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

E. Risk-Sharing Provisions of the Affordable Care Act

(1) The Company has accident and health insurance premiums in 2020 and 2019 subject to the risk-sharing provisions of the ACA.

The ACA imposed 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 corridors.

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. The risk adjustments and distributions are calculated using a high-cost risk pool which adds a reinsurance-like element to this program. The operation of the high-cost risk pools excludes a percentage of costs above a threshold level determined by federal regulations. The program operates two national high-cost risk pools, one for individuals and one for small groups. The data used by CMS to determine the risk adjustment amount is subject to risk adjustment data validation audits along with the true-up to the final CMS report, which may result in a material change to arrive at the final risk adjustment amount from the initial risk adjustment estimate recorded. The risk adjustment data validation audits for 2017 and 2018 has been finalized and any adjustment from the estimate recorded is included in net premium income in the statutory basis financial statements in the period in which the amount became known. The remaining audits for the open years have not been completed. Estimates related to the open years have incorporated CMS' Final Rule on Amendments to the U.S. Department of Health & Human Services ("HHS") operated Risk Adjustment Data Validation under the ACA's HHS-operated Risk Adjustment Program published December 1, 2020 and any estimated amounts receivable from or due to CMS are included in premiums and considerations and aggregate health policy reserves, respectively, in the statutory basis statements of assets, liabilities, and capital and surplus. 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 expired at the end of 2016.

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. The Company received $4,452,364 from CMS for the settlement of the temporary ACA risk corridor program which has been reflected in net premium income in the statutory basis statements of operations. The details of the years impacted and the amounts received are included in Note 24E 4 and Note 24E 5 below.

(2) The following table presents the current year impact of risk-sharing provisions of the ACA on assets, liabilities and operations:

		December 31, 2020
a.	**Permanent ACA Risk Adjustment Program**	
	Assets	
1.	Premium adjustments receivable due to ACA Risk Adjustment (including high-risk pool payments)	$ 5,407
	Liabilities	
2.	Risk adjustment user fees payable for ACA Risk Adjustment	-
3.	Premium adjustments payable due to ACA Risk Adjustment (including high-risk pool premium)	2,683
	Operations (Revenue & Expense)	
4.	Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment	3,755
5.	Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	$ (5)
		-
b.	**Transitional ACA Reinsurance Program**	
	Assets	
1.	Amounts recoverable for claims paid due to ACA Reinsurance	$ -
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.	Liabilities 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	-
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)	4,452,364
4.	Effect of ACA Risk Corridors on change in reserves for rate credits	-

(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 (including high-risk pool payments)	$ 6,381	$ -	$ -	$ -	$ 6,381	$ -	$ (975)	$ -	A	$ 5,406	$ -
2. Premium adjustment (payable) (including high-risk pool premium)	-	(122,193)	-	(114,780)	-	(7,413)	-	4,730	B	-	(2,683)
3. Subtotal ACA Permanent Risk Adjustment Program	6,381	(122,193)	-	(114,780)	6,381	(7,413)	(975)	4,730		5,406	(2,683)
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-	-	-	-	-	-	-	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	-	-	-	-	-	-	-	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. Liabilities for contributions payable due to ACA Reinsurance — not reported as ceded premium	-	-	-	-	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	-	-	-	-	-	-	-	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-	-	4,452,364	-	(4,452,364)	-	4,452,364	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA Risk Corridors Program	-	-	4,452,364	-	(4,452,364)	-	4,452,364	-		-	-
d. Total for ACA Risk-Sharing Provisions	$ 6,381	$ (122,193)	$ 4,452,364	$ (114,780)	$ (4,445,983)	$ (7,413)	$ 4,451,389	$ 4,730		$ 5,406	$ (2,683)

Explanation of Adjustments

A. The risk adjustment receivable as of December 31, 2019 utilized paid claims through October 31, 2019. As of the Reporting Date, the risk adjustment receivable related to prior periods was adjusted based on CMS' Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year. The risk adjustment receivable was further adjusted based on CMS' Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers and estimates related to the open years have incorporated CMS' Final Rule on Amendments to the HHS-operated Risk Adjustment Data Validation (HHS - RADV) under the Patient Protection and Affordable Care Act's HHS-operated Risk Adjustment Program published December 1, 2020.

B. The risk adjustment payable as of December 31, 2019 utilized paid claims through October 31, 2019. As of the Reporting Date, the risk adjustment payable related to the prior period was adjusted based on CMS' Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year. The risk adjustment payable was further adjusted based on CMS' Summary Report of 2018 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers and estimates related to the open years have incorporated CMS' Final Rule on Amendments to the HHS-operated Risk Adjustment Data Validation (HHS - RADV) under the Patient Protection and Affordable Care Act's HHS-operated Risk Adjustment Program published December 1, 2020.

C. N/A

D. N/A

E. N/A

F. N/A

G. N/A

H. N/A

I. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridors program for the 2014, 2015, and 2016 benefit years. The risk corridor payment was recognized in the statutory basis statements of operations upon receipt in full during the quarter ended December 31, 2020.

J. N/A

(4) The following table discloses risk corridor receivables and payables by risk corridor program year:

Risk Corridors Program Year	Accrued during the Prior Year on Business Written before December 31 of the Prior Year 1 Receivable	2 (Payable)	Received or Paid as of the Current Year on Business Written before December 31 of the Prior Year 3 Receivable	4 (Payable)	Differences Prior Year Accrued Less Payments (Col 1 - 3) 5 Receivable	Prior Year Accrued Less Payments (Col 2 - 4) 6 (Payable)	Adjustments To Prior Year Balances 7 Receivable	To Prior Year Balances 8 (Payable)	Ref	Unsettled Balances as of the Reporting Date Cumulative Balance from Prior Years (Col 1 - 3 + 7) 9 Receivable	Cumulative Balance from Prior Years (Col 2 - 4 + 8) 10 (Payable)
a. 2014											
1. Accrued retrospective premium	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	A	$ -	$ -
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	B	-	-
b. 2015											
1. Accrued retrospective premium	-	-	4,251,826	-	(4,251,826)	-	4,251,826	-	C	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	D	-	-
c. 2016											
1. Accrued retrospective premium	-	-	200,538	-	(200,538)	-	200,538	-	E	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	F	-	-
d. Total for Risk Corridors	$ -	$ -	$ 4,452,364	$ -	$ (4,452,364)	$ -	$ 4,452,364	$ -		$ -	$ -

Explanation of Adjustments

A.
B.
C. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridor program covering issuers of qualified health plans in the individual and small group markets for the 2015 benefit year. As of December 31, 2020, the risk corridor payment has been received and is included in net premium income in the statutory basis statements of operations.
D.
E. As a result of the United States Supreme Court decision on April 27, 2020 in Maine Community Health Options vs. United States, the Federal Government paid the full amount due to the Company under the temporary risk corridor program covering issuers of qualified health plans in the individual and small group markets for the 2016 benefit year. As of December 31, 2020, the risk corridor payment has been received and is included in net premium income in the statutory basis statements of operations.
F.

(5) The following table discloses ACA risk corridor receivable balances by risk corridor program year:

Risk Corridors Program Year	1 Estimated Amount to be Filed or Final Amount Filed with CMS	2 Non-Accrued Amounts for Impairment or Other Reasons	3 Amounts Received from CMS	4 Asset Balance (Gross of Non-Admissions) (1 - 2 - 3)	5 Non-Admitted Amount	6 Net Admitted Asset (4 - 5)
a. 2014	$ -	$ -	$ -	$ -	$ -	$ -
b. 2015	4,251,826	-	4,251,826	-	-	-
c. 2016	200,538	-	200,538	-	-	-
d. Total (a + b + c)	$ 4,452,364	$ -	$ 4,452,364	$ -	$ -	$ -

25. CHANGE IN INCURRED CLAIMS AND CLAIMS ADJUSTMENT EXPENSES

A. Changes in estimates related to the prior year incurred claims are included in total hospital and medical expenses in the current year in the statutory basis statements of operations. The following tables disclose paid claims, incurred claims, and the balance in claims unpaid, accrued

medical incentive pool and bonus amounts, aggregate health claim reserves, health care receivables and reinsurance recoverables for the years ended December 31, 2020 and 2019:

	2020		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (318,871,502)	$ (318,871,502)
Paid claims — net of health care receivables and reinsurance recoveries collected	1,888,621,476	281,430,290	2,170,051,766
End of year claim reserve	283,666,620	51,454,880	335,121,500
Incurred claims excluding the change in health care receivables as presented below	2,172,288,096	14,013,668	2,186,301,764
Beginning of year health care receivables	-	39,360,537	39,360,537
End of year health care receivables	(1,762,408)	(61,845,295)	(63,607,703)
Total incurred claims	$ 2,170,525,688	$ (8,471,090)	$ 2,162,054,598

	2019		
	Current Year Incurred Claims	Prior Years Incurred Claims	Total
Beginning of year claim reserve	$ -	$ (249,603,543)	$ (249,603,543)
Paid claims—net of health care receivables and reinsurance recoveries collected	1,765,087,819	185,001,624	1,950,089,443
End of year claim reserve	285,432,095	33,439,407	318,871,502
Incurred claims excluding the change in health care receivables and reinsurance recoverables as presented below	2,050,519,914	(31,162,512)	2,019,357,402
Beginning of year health care receivables	-	33,603,739	33,603,739
End of year health care receivables and reinsurance recoverables	(2,642,606)	(36,717,931)	(39,360,537)
Total incurred claims	$ 2,047,877,308	$ (34,276,704)	$ 2,013,600,604

The liability for claims unpaid, accrued medical incentive pool and bonus amounts, aggregate health claim reserves, net of health care receivables as of December 31, 2019 was $279,510,965. As of December 31, 2020, $281,430,290 has been paid for incurred claims attributable to insured events of prior years. Reserves remaining for prior years, net of health care receivables are now ($10,390,415), as a result of re-estimation of unpaid claims. Therefore, there has been $8,471,090 favorable prior year development since December 31, 2019 to December 31, 2020. The primary drivers consist of favorable development of favorable development as a result of a change in the provision for adverse deviations in experience of $6,450,144, favorable development of $2,893,934 in retroactivity for inpatient, outpatient, physician, and pharmacy claims, and offset by an unfavorable development of $968,468 in reinsurance activity.

At December 31, 2019, the Company recorded $34,276,704 of favorable prior year development. The primary drivers consist of favorable development of $25,883,178 in retroactivity for inpatient, outpatient, physician, and pharmacy claims and favorable development as a result of a change in the provision for adverse deviations in experience of $7,570,058. Original estimates are increased

or decreased, as additional information becomes known regarding individual claims, which could have an impact to the accruals for medical loss ratio rebates and retrospectively rated contracts. 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 change in reserve for rate credits in the statutory basis statements of operations.

The Company incurred CAE of $82,594,580 and $95,129,543 in 2020 and 2019, respectively. These costs are included in the management service fees paid by the Company to UHS as a part of the Agreement (see Note 10). The following table discloses paid CAE, incurred CAE, and the balance in unpaid CAE reserve for 2020 and 2019:

	2020	2019
Total claims adjustment expenses	$ 82,594,580	$ 95,129,543
Less: current year unpaid claims adjustment expenses	(1,427,483)	(1,111,430)
Add: prior year unpaid claims adjustment expenses	1,111,430	1,351,967
Total claims adjustment expenses paid	$ 82,278,527	$ 95,370,080

B. The Company did not make any significant changes in methodologies and assumptions used in the calculation of the liability for claims unpaid and unpaid CAE in 2020.

26. INTERCOMPANY POOLING ARRANGEMENTS

A–G. The Company did not have any intercompany pooling arrangements in 2020 or 2019.

27. STRUCTURED SETTLEMENTS

A–B. The Company did not have structured settlements in 2020 or 2019.

28. HEALTH CARE RECEIVABLES

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, *Health Care and Government Insured Plan Receivables* (“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
12/31/2020	$ 843,212	$ 3,995	$ -	$ -	$ -
9/30/2020	860,284	751,299	488,839	-	-
6/30/2020	841,717	711,517	458,620	231,754	-
3/31/2020	1,452,617	749,765	1,855	674,194	90,470
12/31/2019	985,672	982,238	235,292	707,720	17,411
9/30/2019	532,900	996,884	201,224	109,474	666,836
6/30/2019	2,110,736	2,666,017	1,710,608	787,932	126,799
3/31/2019	5,890,908	6,014,885	3,300,991	1,715,908	890,058
12/31/2018	7,084,291	6,742,851	4,797,119	1,840,214	185,963
9/30/2018	6,505,071	6,496,554	3,843,911	2,059,957	533,626
6/30/2018	6,775,195	6,685,163	3,797,795	2,248,025	577,642
3/31/2018	6,788,436	6,537,489	3,031,387	2,776,322	689,231

Of the amount reported as health care receivables, $1,097,992 and $1,838,636 relates to pharmacy rebates receivable as of December 31, 2020 and 2019, respectively. This decrease is primarily due to decreased commercial membership.

B. The Company does not have any risk-sharing receivables.

The Company also admitted $626,500 and $975,414 of provider receivables resulting from claim overpayments as of December 31, 2020 and December 31, 2019, respectively, which are included in health care receivables in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

29. PARTICIPATING POLICIES

The Company did not have any participating contracts in 2020 or 2019.

30. PREMIUM DEFICIENCY RESERVES

The following table summarizes the Company's PDR as of December 31, 2020 and 2019:

	2020
1. Liability carried for premium deficiency reserves	$ -
2. Date of the most recent evaluation of this liability	12/31/2020
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

	2019
1. Liability carried for premium deficiency reserves	$ 222,333,000
2. Date of the most recent evaluation of this liability	12/31/2019
3. Was anticipated investment income utilized in this calculation?	Yes [X] No [ ]

PDR is included in aggregate health policy reserves in the statutory basis statements of admitted assets, liabilities, and capital and surplus.

31. ANTICIPATED SALVAGE AND SUBROGATION

Due to the type of business being written, the Company has no salvage. As of December 31, 2020 and 2019, 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 claims unpaid and aggregate health claim reserves.

32. RECONCILIATION TO THE ANNUAL STATEMENT

During the audit of 2019 statutory basis financial statements, necessary adjustments were discovered during the subsequent event review related to changes in the PDR from what was previously filed by the Company to the 2019 Annual submission on March 1, 2020.

The following table reconciles the 2020 Annual Statement previously filed to the 2020 statutory basis financial statements:

	Per Audited Statutory Basis Financial Statements	Per Annual Statement	Variance
Expenses	$ 2,470,807,505	$ 2,465,169,505	$ 5,638,000
Net income	105,053,768	110,691,768	(5,638,000)

The following table is also provided for additional information regarding the impact of the adjustments to 2020 net income:

Net income per annual statement	$ 110,691,768
Adjustment to decrease in reserves for accident and health contracts	(5,638,000)
Net income per statutory basis financial statements	$ 105,053,768

The result of the adjustments made to the 2020 statutory basis financial statements is a net decrease in net income of $5,638,000.

The following table reconciles the 2019 Annual Statement previously filed to the 2019 statutory basis financial statements:

	Per Audited Statutory Basis Financial Statements	Per Annual Statement	Variance
Assets	$ 626,088,108	$ 627,272,088	$ (1,183,980)
Liabilities	441,074,198	446,712,198	(5,638,000)
Capital and surplus	185,013,910	180,559,890	4,454,020
Expenses	2,299,158,018	2,327,605,018	(28,447,000)
Net income	48,916,184	20,469,184	28,447,000

The following table is also provided for additional information regarding the impact of the adjustments to capital and surplus:

Capital and surplus per annual statement	$ 180,559,890
Change in net deferred income taxes	(1,183,980)
Adjustment to decrease in reserves for accident and health contracts	5,638,000
Capital and surplus per statutory basis financial statements	$ 185,013,910

The following table is also provided for additional information regarding the impact of the adjustments to 2019 net income:

Net income per annual statement	$ 20,469,184
Adjustment to decrease in reserves for accident and health contracts	28,447,000
Net income per statutory basis financial statements	$ 48,916,184

The result of the adjustments made to the 2019 statutory basis financial statements is an increase to total capital and surplus of $4,454,020 and an increase in net income of $28,447,000.

* * * * * * *

SUPPLEMENTAL SCHEDULES

EXHIBIT I:
SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2020
(To Be Filed by April 1)

Of The UnitedHealthcare of Louisiana, Inc.

ADDRESS (City, State and Zip Code) Minnetonka , MN 55343

NAIC Group Code 0707 NAIC Company Code 95833 Federal Employer's Identification Number (FEIN) 72-1074008

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. $ 732,833,064

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	BlackRock - TFFXX	Bonds	$ 20,000,000	2.7 %
2.02	HSBC - HGIXX	Bonds	$ 14,370,111	2.0 %
2.03	First American - FGZXX	Bonds	$ 10,144,251	1.4 %
2.04	FNMA	Bonds	$ 9,934,695	1.4 %
2.05	FHLMC	Bonds	$ 8,102,082	1.1 %
2.06	DEUTSCHE GOV - ICAXX	Bonds	$ 4,268,420	0.6 %
2.07	BANK OF AMERICA	Bonds	$ 3,848,131	0.5 %
2.08	JPMORGAN CHASE	Bonds	$ 3,789,522	0.5 %
2.09	CATERPILLAR INC	Bonds	$ 3,607,096	0.5 %
2.10	BB&T CORPORATION	Bonds	$ 3,397,549	0.5 %

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	$ 197,642,256	27.0 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 43,783,775	6.0 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 0	0.0 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 0	0.0 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	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 [X] No [ ]

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	$ 0	0.0 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 0	0.0 %
5.02	Countries designated NAIC-2	$ 0	0.0 %
5.03	Countries designated NAIC-3 or below	$ 0	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:	$ 0	0.0 %
6.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
6.03	Country 1:	$ 0	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1:	$ 0	0.0 %
6.06	Country 2:	$ 0	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			$ 0	0.0 %
10.02			$ 0	0.0 %
10.03			$ 0	0.0 %
10.04			$ 0	0.0 %
10.05			$ 0	0.0 %
10.06			$ 0	0.0 %
10.07			$ 0	0.0 %
10.08			$ 0	0.0 %
10.09			$ 0	0.0 %
10.10			$ 0	0.0 %

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 [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	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 14.02 through 14.05.

	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 %

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06		$ 0	$ 0	$ 0
14.07		$ 0	$ 0	$ 0
14.08		$ 0	$ 0	$ 0
14.09		$ 0	$ 0	$ 0
14.10		$ 0	$ 0	$ 0
14.11		$ 0	$ 0	$ 0
14.12		$ 0	$ 0	$ 0
14.13		$ 0	$ 0	$ 0
14.14		$ 0	$ 0	$ 0
14.15		$ 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 1 Amount	Gross Investment Holdings 2 Percentage of Column 1 Line 13	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage of Column 5 Line 13
1.	Long-Term Bonds (Schedule D, Part 1):						
	1.01 U.S. governments	23,697,152	4.678	23,697,152	0	23,697,152	4.678
	1.02 All other governments	0	0.000	0	0	0	0.000
	1.03 U.S. states, territories and possessions, etc. guaranteed	13,913,042	2.746	13,913,042	0	13,913,042	2.746
	1.04 U.S. political subdivisions of states, territories, and possessions, guaranteed	25,714,460	5.076	25,714,460	0	25,714,460	5.076
	1.05 U.S. special revenue and special assessment obligations, etc. non-guaranteed	55,559,375	10.967	55,559,375	0	55,559,375	10.967
	1.06 Industrial and miscellaneous	122,542,002	24.189	122,542,002	0	122,542,002	24.189
	1.07 Hybrid securities	0	0.000	0	0	0	0.000
	1.08 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	1.09 SVO identified funds	0	0.000	0	0	0	0.000
	1.10 Unaffiliated Bank loans	0	0.000	0	0	0	0.000
	1.11 Total long-term bonds	241,426,031	47.655	241,426,031	0	241,426,031	47.655
2.	Preferred stocks (Schedule D, Part 2, Section 1):						
	2.01 Industrial and miscellaneous (Unaffiliated)	0	0.000	0	0	0	0.000
	2.02 Parent, subsidiaries and affiliates	0	0.000	0	0	0	0.000
	2.03 Total preferred stocks	0	0.000	0	0	0	0.000
3.	Common stocks (Schedule D, Part 2, Section 2):						
	3.01 Industrial and miscellaneous Publicly traded (Unaffiliated)	0	0.000	0	0	0	0.000
	3.02 Industrial and miscellaneous Other (Unaffiliated)	0	0.000	0	0	0	0.000
	3.03 Parent, subsidiaries and affiliates Publicly traded	0	0.000	0	0	0	0.000
	3.04 Parent, subsidiaries and affiliates Other	0	0.000	0	0	0	0.000
	3.05 Mutual funds	0	0.000	0	0	0	0.000
	3.06 Unit investment trusts	0	0.000	0	0	0	0.000
	3.07 Closed-end funds	0	0.000	0	0	0	0.000
	3.08 Total common stocks	0	0.000	0	0	0	0.000
4.	Mortgage loans (Schedule B):						
	4.01 Farm mortgages	0	0.000	0	0	0	0.000
	4.02 Residential mortgages	0	0.000	0	0	0	0.000
	4.03 Commercial mortgages	0	0.000	0	0	0	0.000
	4.04 Mezzanine real estate loans	0	0.000	0	0	0	0.000
	4.05 Total valuation allowance	0	0.000	0	0	0	0.000
	4.06 Total mortgage loans	0	0.000	0	0	0	0.000
5.	Real estate (Schedule A):						
	5.01 Properties occupied by company	0	0.000	0	0	0	0.000
	5.02 Properties held for production of income	0	0.000	0	0	0	0.000
	5.03 Properties held for sale	0	0.000	0	0	0	0.000
	5.04 Total real estate	0	0.000	0	0	0	0.000
6.	Cash, cash equivalents and short-term investments:						
	6.01 Cash (Schedule E, Part 1)	52,653	0.010	52,653	0	52,653	0.010
	6.02 Cash equivalents (Schedule E, Part 2)	262,697,267	51.854	262,697,267	0	262,697,267	51.854
	6.03 Short-term investments (Schedule DA)	0	0.000	0	0	0	0.000
	6.04 Total cash, cash equivalents and short-term investments	262,749,920	51.864	262,749,920	0	262,749,920	51.864
7.	Contract loans	0	0.000	0	0	0	0.000
8.	Derivatives (Schedule DB)	0	0.000	0	0	0	0.000
9.	Other invested assets (Schedule BA)	2,434,863	0.481	2,434,863	0	2,434,863	0.481
10.	Receivables for securities	0	0.000	0	0	0	0.000
11.	Securities Lending (Schedule DL, Part 1)	0	0.000	0	XXX	XXX	XXX
12.	Other invested assets (Page 2, Line 11)	0	0.000	0	0	0	0.000
13.	Total invested assets	506,610,814	100.000	506,610,814	0	506,610,814	100.000

EXHIBIT III:
SUPPLEMENTAL SCHEDULE
REGARDING REINSURANCE CONTRACTS
WITH RISK-LIMITING FEATURES

UNITEDHEALTHCARE OF LOUISIANA, INC.

FOR THE YEAR ENDED DECEMBER 31, 2020
SUPPLEMENTAL SCHEDULE OF THE ANNUAL AUDIT REPORT
SUPPLEMENTAL SCHEDULE REGARDING REINSURANCE CONTRACTS WITH RISK–LIMITING FEATURES

Reinsurance contracts subject to Appendix A-791 — L*ife and Health Reinsurance Agreements of the NAIC Accounting Practices and Procedures Manual*:

The Company has no reinsurance contracts subject to Appendix A-791 – Life and Health Reinsurance Agreements ("A-791") that includes a provision which limits the reinsurer's assumption of significant risk.

Reinsurance contracts NOT subject to Appendix A-791 — *Life and Health Reinsurance Agreements of the NAIC Accounting Practices and Procedures Manual*:

The Company has no reinsurance contracts not subject to A-791, for which reinsurance accounting was applied and which include a provision that limits the reinsurer's assumption of risk.

Payments to reinsurers (excluding reinsurance contracts with a federal or state facility):

The Company's reinsurance contracts do not contain features which result in delays in payment in form or in fact.

Reinsurance contracts NOT subject to Appendix A-791 — *Life and Health Reinsurance Agreements of the NAIC Accounting Practices and Procedures Manual* and NOT yearly-renewable term that meet the risk transfer requirements under SSAP No. 61R:

The Company has not reflected a reinsurance accounting credit for any contracts not subject to Appendix A-791 and not yearly renewable term, which meet the risk transfer requirements of SSAP No. 61R, *Life, Deposit-Type, and Accident and Health Reinsurance* ("SSAP No. 61R").

The Company did not cede any risk which is not subject to A-791 and not yearly renewable term reinsurance, under any reinsurance contract during the period covered by these financial statements, for which the statutory accounting treatment and GAAP accounting treatment were not the same.

The Company's ceded reinsurance contract which are not subject to A-791 and not yearly renewable term reinsurance, is treated the same for GAAP and statutory accounting principles.

OTHER ATTACHMENT

Deloitte.

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Minneapolis, MN 55402-1538
USA

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www.deloitte.com

To the Audit Committee of
UnitedHealthcare of Louisiana, Inc.
3838 N. Causeway Boulevard, Suite 2600
Metairie, LA 70002

The Management of
UnitedHealthcare of Louisiana, Inc.
3838 N. Causeway Boulevard, Suite 2600
Metairie, LA 70002

Dear Members of the 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 of Louisiana, Inc. (the "Company") for the years ended December 31, 2020, and 2019, and have issued our report thereon dated April 16, 2021. In connection therewith, we advise you as follows:

1. 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 Louisiana Department of Insurance, and the Rules of Professional Conduct of the Minnesota State Board of Accountancy.

2. The engagement partner and engagement manager, who are certified public accountants, have 16 years and 8 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 32 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

3. We understand that the Company intends to file its audited statutory-basis financial statements and our report thereon with the Louisiana Department of Insurance 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 Louisiana Department of Insurance. 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 Louisiana Department of Insurance.

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.

4. We will retain the working papers (including those kept in a hard copy or electronic medium) prepared in the conduct of our audit until the Louisiana Department of Insurance has filed a Report of Examination covering 2020, but no longer than seven years. After notification to the Company, we will make the working papers available for review by the Louisiana Department of Insurance or its delegates, at the offices of the insurer, at our offices, at the Louisiana Department of Insurance, or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Louisiana Department of Insurance, photocopies of pertinent audit working papers may be made (under the control of Deloitte & Touche LLP) and such copies may be retained by the Louisiana Department of Insurance. In addition, to the extent requested, we may provide the Louisiana Department of Insurance with copies of certain audit working papers (such as unlocked copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by Louisiana Department of Insurance or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Louisiana Department of Insurance; and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance, or outcome of your regulatory examination.

5. The engagement partner has served in this capacity with respect to the Company since 2019, is licensed by the Minnesota State Board of Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

6. 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 of Louisiana, Inc. and for filing with the Louisiana Department of Insurance 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

April 16, 2021

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2018

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	
(Address of principal executive offices)	**55343** **(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

COMMON STOCK, $.01 PAR VALUE	**NEW YORK STOCK EXCHANGE, INC.**
(Title of each class)	**(Name of each exchange on which registered)**

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2018 was $234,490,429,732 (based on the last reported sale price of $245.34 per share on June 30, 2018, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2019, there were 959,538,515 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2019 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

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PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes the provision of health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2018, we processed more than three-quarters of a trillion dollars in gross billed charges and we managed more than $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- strong local-market relationships;

- the breadth of product offerings, which are responsive to many distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1.3 million physicians and other health care professionals and more than 6,000 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. UnitedHealthcare Employer & Individual provides access to medical services for 27 million people on behalf of our customers and alliance partners, including employer customers serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace,

UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing, life, transportation, critical illness and disability product offerings using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 4.9 million people through its Medicare Advantage products as of December 31, 2018.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live healthier lives. Through our HouseCalls program, nurse practitioners performed 1.5 million in-home preventive care visits in 2018 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across

home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2018, UnitedHealthcare enrolled 9.0 million people in the Medicare Part D programs, including 4.7 million individuals in the stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.9 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from CMS represented 30% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2018, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and people without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF), Children's Health Insurance Programs (CHIP), Dual SNPs (DSNPs), Aged, Blind and Disabled and other federal, state and community health care programs. As of December 31, 2018, UnitedHealthcare Community & State participated in programs in 30 states and the District of Columbia, and served 6.5 million people; including 1 million people through Medicaid expansion programs in 15 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care

providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants that can affect people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 50% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care, which represents a population of nearly 8 million people; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care. This expansion includes integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% who are most at risk drive over 50% of states' medical costs.

UnitedHealthcare Global

UnitedHealthcare Global serves 6.2 million people with medical benefits, residing principally in Brazil, Chile, Colombia and Peru but also in more than 130 other countries. UnitedHealthcare Global owns and operates more than 300 hospitals, specialty centers, primary care and emergency services clinics in South America and Portugal. UnitedHealthcare Global provides a comprehensive range of health and mobilization capabilities and supports the health systems of individual nations with support for improving health care financing and delivery. Clients include multi-national and local businesses, governments and individual consumers around the world.

Global Markets. UnitedHealthcare Global serves local populations in select markets around the world, primarily in Brazil; Chile; Colombia; Peru; and Portugal, by touching nearly every aspect of health care and leveraging expertise in clinical care management and health care data to improve outcomes, raise quality and constrain costs.

In Brazil, Amil provides health benefits to 4.1 million people through a broad network of owned and affiliated clinics, hospitals and care providers. Dental benefits are also provided to 2.2 million people. Amil's members have access to a provider network of physicians and other health care professionals, hospitals, laboratories and diagnostic imaging centers. Americas Serviços Médicos offers health care delivery in Brazil through hospitals, ambulatory clinics and surgery centers to Amil members and consumers served by the external payer market.

Empresas Banmédica provides health benefits and health care services to 2.1 million people in Chile, Colombia and Peru through a network of owned and affiliated clinics, hospitals and care providers. Empresas Banmédica owns and operates hospitals, clinics and outpatient centers.

Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

Global Solutions. UnitedHealthcare Global includes other diversified global health services with a variety of offerings for international customers.

Optum

Optum is a technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.

- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight specializes in data and analytics and other health care information technology services, and delivers operational services and support; and
- OptumRx provides pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 93 million unique individuals. OptumHealth enables population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health and by coordinating care for the most medically complex patients.

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of more than 35,000 employed, managed or contracted physicians. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance- based delivery and payment models that improve the focus on patient health and outcomes, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care. MedExpress' neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach and Surgical Care Affiliates' independent ambulatory surgical centers and surgical hospitals provide high-value surgical services at a substantially lower cost than a traditional in-patient hospital setting.

OptumServe provides a wide range of health services specifically tailored to active military and veterans and the agencies that support them.

OptumHealth serves people through population health services that meet both the preventive care and health intervention needs of consumers across the care continuum—physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through 5.2 million health savings and other accounts approaching $10 billion in assets under management as of

December 31, 2018. During 2018, Optum Bank processed nearly $160 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served, or on a fee-for-service basis, where it delivers medical services to patients in exchange for a contracted fee. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, the Department of Defense, the Veterans Administration and other federal procurement agencies).

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on technology, research and consulting and managed services that help improve the quality of care and drive greater efficiency in the health care system. Technology includes population health and risk analytics, administrative and clinical technology for claims editing, risk adjustment and payment integrity, health information and electronic data exchange and technology strategy and management. Research and consulting helps organizations reduce administrative costs and implement best practices to improve clinical performance. Managed services provides solutions such as revenue cycle management, risk analytics, payment integrity outsourcing and state Medicaid data and technology management. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2018 was $17.0 billion, of which $8.6 billion is expected to be realized within the next 12 months. The aggregate backlog includes $6.2 billion related to intersegment agreements. OptumInsight's aggregate backlog at December 31, 2017, was $15.0 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving more than four out of five U.S. hospitals and more than 100,000 physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers

meet these challenges, with particular focus on clinical performance and quality improvement, population health, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves three out of four U.S. health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to 65 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and compounding pharmacies and through the provision of home infusion services. In 2018, OptumRx added capabilities in managing limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology as well as capabilities to serve the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2018, OptumRx managed $91 billion in pharmaceutical spending, including $40 billion in specialty pharmaceutical spending.

OptumRx provides pharmacy care services to a number of health plans, including a substantial majority of UnitedHealthcare members, large national employer plans, unions and trusts and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner, which are designed to promote good health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that affect member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care, using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and members.

As of December 31, 2018, OptumRx operated four home delivery pharmacies in the United States, which provide patients with access to maintenance medications and enables OptumRx to manage clients' drug costs through operating efficiencies and economies of scale. As of December 31, 2018, OptumRx's specialty pharmacy operations included more than 70 specialty and infusion pharmacies located throughout the United States that are used for delivery of advanced medications to people with chronic or genetic diseases and disorders. OptumRx also operates community mental health facility pharmacies, which help align benefits, care management and pharmacy services for those living with complex, chronic medical and behavioral health issues.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. We are also subject to federal law and regulations relating to the administration of contracts with federal agencies. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust compliance.

The Tax Cuts and Jobs Act. In December 2017, the U.S. federal government enacted a tax bill (Tax Cuts and Jobs Act or Tax Reform). The Tax Cuts and Jobs Act changed existing United States tax law and included numerous provisions that affected our results of operations, financial position and cash flows. For instance, Tax Reform reduced the U.S. corporate income tax rate and changed business-related exclusions and deductions and credits.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposed requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extended parts of HIPAA privacy and security provisions to business associates; added federal data

breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthened enforcement and imposed higher financial penalties for HIPAA violations and, in certain cases, imposed criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by that state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to

state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and protected health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices that involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx’s businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery, specialty and compounding pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our home delivery, specialty and compounding pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery, specialty and compounding pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Additionally, certain of our pharmacies that participate in programs for Medicare and state Medicaid providers are required to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards that impact PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve, which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, "Risk Factors" for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2018, we employed 300,000 individuals.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following sets forth certain information regarding our executive officers as of February 12, 2019, including the business experience of each executive officer during the past five years:

Name	Age	Position
Stephen J. Hemsley	66	Executive Chair of the Board
David S. Wichmann	56	Chief Executive Officer
Steven H. Nelson	59	Executive Vice President; Chief Executive Officer of UnitedHealthcare
Andrew P. Witty	54	Executive Vice President; Chief Executive Officer of Optum
John F. Rex	56	Executive Vice President; Chief Financial Officer
Thomas E. Roos	46	Senior Vice President; Chief Accounting Officer
Marianne D. Short	67	Executive Vice President; Chief Legal Officer
D. Ellen Wilson	61	Executive Vice President; Chief Human Resources Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Hemsley is Executive Chair of the Board of UnitedHealth Group and has served in that capacity since September 2017. Mr. Hemsley previously served as Chief Executive Officer from 2006 to August 2017. He has been a member of the Board of Directors since 2000.

Mr. Wichmann is Chief Executive Officer of UnitedHealth Group and a member of the Board of Directors and has served in that capacity since September 2017. Mr. Wichmann previously served as President of UnitedHealth

Group from November 2014 to August 2017. Mr. Wichmann also served as Chief Financial Officer of UnitedHealth Group from January 2011 to June 2016. From April 2008 to November 2014, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Mr. Nelson is Executive Vice President of UnitedHealth Group and Chief Executive Officer of UnitedHealthcare and has served in that capacity since August 2017. Mr. Nelson served as Chief Executive Officer of UnitedHealthcare's Medicare & Retirement, from March 2014 to August 2017. He served as Chief Executive Officer of UnitedHealthcare Community & State from August 2012 to March 2014. From January 2008 to July 2012 he served as President of UnitedHealthcare Community & State and then as Chief Executive Officer of UnitedHealthcare Employer & Individual's West Region business.

Mr. Witty is Executive Vice President of UnitedHealth Group and Chief Executive Officer of Optum and has served in that capacity since July 2018. He previously served as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, Mr. Witty was CEO and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex spent over a decade at JP Morgan, a global financial services firm, and its predecessors, concluding his tenure as a Managing Director.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President and Chief Human Resources Officer of UnitedHealth Group and has served in that capacity since June 2013. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments, concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our company. From that site, you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. Premium revenues from risk-based benefits products comprise nearly 80% of our total consolidated revenues. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. In addition, our OptumHealth business negotiates capitation arrangements with commercial third-party payers. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. If we fail to predict accurately, or effectively price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts are typically based on a fixed monthly rate per individual served for a 12-month period

and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2018 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2018 would have been reduced by approximately $305 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. 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. Any such assessment could expose our insurance entities and other insurers to the risk that they would be required to pay a portion of an impaired or insolvent insurance company’s claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our UnitedHealthcare and Optum businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations that are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified or repealed or replaced. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part; and a federal district court struck down the ACA in its entirety as unconstitutional in 2018. That opinion has been stayed and appealed. Further, the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while the Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations that could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial

revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly 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 for Medicare Advantage plans,

as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. For example, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and corporate integrity agreements. Additionally, such investigations, audits or reviews sometimes arise out of, or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we sustain cyber-attacks or other privacy or data security incidents that result in security breaches that disrupt our operations or result in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place that are intended to detect, contain and respond to data security incidents and that provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause system shutdowns that could negatively affect our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human error; malicious social engineering; or other events that could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or

cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA imposed further restrictions on our ability to collect, disclose and use protected personal information and imposed additional compliance requirements on our business.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect that there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, goes into effect in 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities and expand it to include business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the FDA and Boards of Pharmacy. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine that fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other health care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services that are useful and relevant to consumers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care

usage, and we may face challenges from new technologies and market entrants that could affect our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider, under the capitation arrangement. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard

that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. There is and will likely be heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We are also party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. If we were subjected to similar investigations and enforcement actions, such actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2018. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2018, our goodwill and other intangible assets had a carrying value of $68 billion, representing 45% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely impact our credit ratings and potentially impact our compliance with the financial covenants in our bank credit facilities.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our ability to price adequately our products and services, to provide effective service to our customers in an efficient and uninterrupted fashion, and to report accurately our results of operations depends on the integrity of the data in our information systems. We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the information we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could lose existing customers, have difficulty attracting new customers, experience problems in determining medical cost estimates and establishing appropriate pricing, have difficulty preventing, detecting and controlling fraud, have disputes with customers, physicians and other health care professionals, become subject to regulatory sanctions or penalties, incur increases in operating expenses or suffer other adverse consequences. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. Connectivity among competing technologies is becoming increasingly important in the health care industry. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to the health information technology market may present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2019, there were 11,948 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2018, our Board of Directors increased the Company's annual cash dividend rate to shareholders to $3.60 per share compared to $3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2018, we repurchased 3.3 million shares at an average price of $256.15 per share. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock.

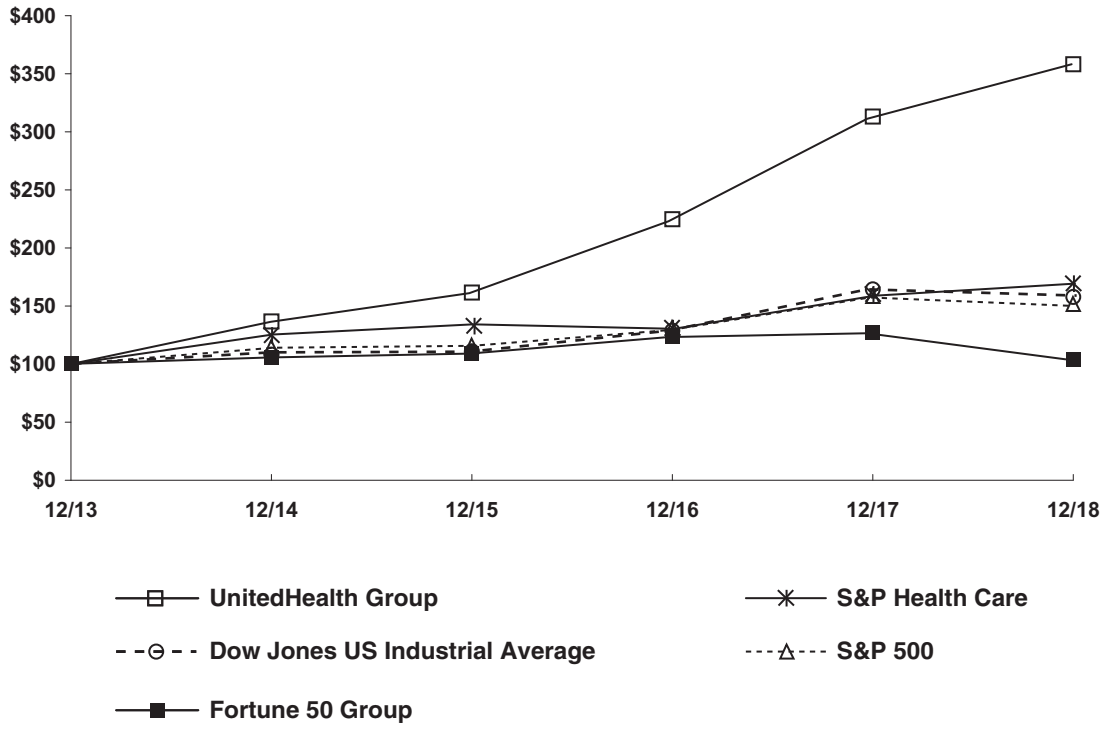
PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index, the S&P Health Care Index and the Dow Jones US Industrial Average Index for the five-year period ended December 31, 2018. We have also included the customized peer group of certain *Fortune 50* companies that we have compared ourselves to in prior years. We believe that these indices provide a more meaningful comparison than the previous subset of the Fortune 50 given our diverse businesses. The comparisons assume the investment of $100 on December 31, 2013 in our common stock and in each index, and that dividends were reinvested when paid.

The *Fortune 50* Group consists of the following companies: American International Group, Inc., Berkshire Hathaway Inc., Cardinal Health, Inc., Citigroup Inc., General Electric Company, International Business Machines Corporation and Johnson & Johnson. We are not included in this *Fortune 50* Group index. In calculating the cumulative total shareholder return of the indexes, the shareholder returns of the *Fortune 50* Group companies are weighted according to the stock market capitalizations of the companies at January 1 of each year.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P Health Care Index, the Dow Jones US Industrial Average Index, the S&P 500 Index, and Fortune 50 Group



	12/13	12/14	12/15	12/16	12/17	12/18
UnitedHealth Group	**$100.00**	**$136.46**	**$161.37**	**$223.35**	**$312.29**	**$357.64**
S&P Health Care Index	**100.00**	**125.34**	**133.97**	**130.37**	**159.15**	**169.44**
Dow Jones US Industrial Average	**100.00**	**110.04**	**110.28**	**128.47**	**164.58**	**158.85**
S&P 500 Index	**100.00**	**113.69**	**115.26**	**129.05**	**157.22**	**150.33**
Fortune 50 Group	**100.00**	**105.33**	**108.75**	**123.33**	**126.45**	**103.96**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Years Ended December 31, 2018	2017 (a)	2016	2015 (b)	2014
Consolidated operating results					
Revenues	$226,247	$201,159	$184,840	$157,107	$130,474
Earnings from operations	17,344	15,209	12,930	11,021	10,274
Net earnings attributable to UnitedHealth Group common shareholders	11,986	10,558	7,017	5,813	5,619
Return on equity (c)	24.4%	24.4%	19.4%	17.7%	17.3%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 12.45	$ 10.95	$ 7.37	$ 6.10	$ 5.78
Diluted earnings per share attributable to UnitedHealth Group common shareholders	12.19	10.72	7.25	6.01	5.70
Cash dividends declared per common share	3.45	2.875	2.375	1.875	1.405
Consolidated cash flows from (used for)					
Operating activities	$ 15,713	$ 13,596	$ 9,795	$ 9,740	$ 8,051
Investing activities	(12,385)	(8,599)	(9,355)	(18,395)	(2,534)
Financing activities	(4,365)	(3,441)	(1,011)	12,239	(5,293)
Consolidated financial condition (as of December 31)					
Cash and investments	$ 46,834	$ 43,831	$ 37,143	$ 31,703	$ 28,063
Total assets	152,221	139,058	122,810	111,254	86,300
Total commercial paper and long-term debt	36,554	31,692	32,970	31,965	17,324
Redeemable noncontrolling interests	1,908	2,189	2,012	1,736	1,388
Total equity	54,319	49,833	38,177	33,725	32,454

(a) Includes the impact of the revaluation of our net deferred tax liabilities due to Tax Reform enacted in December 2017.

(b) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

This selected financial data should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements and Supplementary Data." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified family of businesses, we leverage core competencies in data analytics and health information; advanced technology; and clinical expertise. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which have impacted and could further impact our results of operations.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs amid reform changes. The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2018 federal budget imposed a one year moratorium for 2019 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover a portion of calendar year 2019 reflected the impact of the moratorium. The industry has continued to experience favorable medical cost trends due to moderated utilization, which has impacted the competitive pricing environment.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect continued Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe that the payment rate environment creates the risk of downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2018, we served nearly 17 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2018, our contracts with value-based elements totaled $74 billion in annual spending, including $18 billion through risk-transfer agreements.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2019 Medicare Advantage rates resulted in an increase in industry base rates of 3.4%, short of the industry forward medical cost trend, which creates continued pressure in the Medicare Advantage program.

The ongoing pressure on Medicare Advantage funding places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums that supplement the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

As Medicare Advantage payments change, other products may become relatively more attractive to Medicare beneficiaries and increase the demand for other senior health benefits products, such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

Tax Reform. Tax Reform was enacted by the U.S federal government in December 2017, changing existing United States tax law, including reducing the U.S. corporate income tax rate. In 2018, the impact of Tax Reform was partially offset by the return of the nondeductible Health Insurance Industry Tax.

Health Insurance Industry Tax. After a moratorium in 2017, the industry-wide amount of the Health Insurance Industry Tax in 2018 was $14.3 billion, with our portion being $2.6 billion. The return of the tax impacted year-over-year comparability of our financial results, including revenues, the medical care ratio (MCR), operating cost ratio and effective tax rate. A one year moratorium is imposed on the collection of the Health Insurance Industry Tax in 2019.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2018 year-over-year operating comparisons to 2017.

- Consolidated revenues increased by 12%, UnitedHealthcare revenues increased 12% and Optum revenues grew 11%.
- UnitedHealthcare's addition of 2.2 million people through acquisition and 250,000 through organic growth was offset by 2.9 million fewer people served as a result of completion of its commitment under the TRICARE military health care program.
- Earnings from operations increased by 14%, including increases of 7% at UnitedHealthcare and 23% at Optum.
- Diluted earnings per common share increased 14% to $12.19.
- Cash flows from operations were $15.7 billion, an increase of 16%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
Revenues:							
Premiums	$178,087	$158,453	$144,118	$19,634	12%	$14,335	10%
Products	29,601	26,366	26,658	3,235	12	(292)	(1)
Services	17,183	15,317	13,236	1,866	12	2,081	16
Investment and other income	1,376	1,023	828	353	35	195	24
Total revenues	226,247	201,159	184,840	25,088	12	16,319	9
Operating costs:							
Medical costs	145,403	130,036	117,038	15,367	12	12,998	11
Operating costs	34,074	29,557	28,401	4,517	15	1,156	4
Cost of products sold	26,998	24,112	24,416	2,886	12	(304)	(1)
Depreciation and amortization	2,428	2,245	2,055	183	8	190	9
Total operating costs	208,903	185,950	171,910	22,953	12	14,040	8
Earnings from operations	17,344	15,209	12,930	2,135	14	2,279	18
Interest expense	(1,400)	(1,186)	(1,067)	(214)	18	(119)	11
Earnings before income taxes	15,944	14,023	11,863	1,921	14	2,160	18
Provision for income taxes	(3,562)	(3,200)	(4,790)	(362)	11	1,590	(33)
Net earnings	12,382	10,823	7,073	1,559	14	3,750	53
Earnings attributable to noncontrolling interests	(396)	(265)	(56)	(131)	49	(209)	373
Net earnings attributable to UnitedHealth Group common shareholders	$ 11,986	$ 10,558	$ 7,017	$ 1,428	14%	$ 3,541	50%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 12.19	$ 10.72	$ 7.25	$ 1.47	14%	$ 3.47	48%
Medical care ratio (a)	81.6%	82.1%	81.2%	(0.5)%		0.9%	
Operating cost ratio	15.1	14.7	15.4	0.4		(0.7)	
Operating margin	7.7	7.6	7.0	0.1		0.6	
Tax rate	22.3	22.8	40.4	(0.5)		(17.6)	
Net earnings margin (b)	5.3	5.2	3.8	0.1		1.4	
Return on equity (c)	24.4%	24.4%	19.4%	—%		5.0%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2018 RESULTS OF OPERATIONS COMPARED TO 2017 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by the increase in the number of individuals served through risk-based products across our UnitedHealthcare benefits businesses; pricing trends, including the Health Insurance

Industry Tax in 2018; and growth across the Optum business, primarily due to expansion and growth in care delivery, pharmacy care services, managed services and advisory services.

Medical Costs and MCR

Medical costs increased due to growth in people served through risk-based products and medical cost trends. The MCR decreased due to the revenue effects of the Health Insurance Industry Tax, which more than offset business mix changes and a lower level of favorable reserve development.

Reportable Segments

See Note 13 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more information on our segments. The following table presents a summary of the reportable segment financial information:

	For the Years Ended December 31,			Change		Change	
(in millions, except percentages)	2018	2017	2016	2018 vs. 2017		2016 vs. 2015	
Revenues							
UnitedHealthcare	$183,476	$163,257	$148,581	$20,219	12%	$14,676	10%
OptumHealth	24,145	20,570	16,908	3,575	17	3,662	22
OptumInsight	9,008	8,087	7,333	921	11	754	10
OptumRx	69,536	63,755	60,440	5,781	9	3,315	5
Optum eliminations	(1,409)	(1,227)	(1,088)	(182)	15	(139)	13
Optum	101,280	91,185	83,593	10,095	11	7,592	9
Eliminations	(58,509)	(53,283)	(47,334)	(5,226)	10	(5,949)	13
Consolidated revenues	$226,247	$201,159	$184,840	$25,088	12%	$16,319	9%
Earnings from operations							
UnitedHealthcare	$ 9,113	$ 8,498	$ 7,307	$ 615	7%	$ 1,191	16%
OptumHealth	2,430	1,823	1,428	607	33	395	28
OptumInsight	2,243	1,770	1,513	473	27	257	17
OptumRx	3,558	3,118	2,682	440	14	436	16
Optum	8,231	6,711	5,623	1,520	23	1,088	19
Consolidated earnings from operations	$ 17,344	$ 15,209	$ 12,930	$ 2,135	14%	$ 2,279	18%
Operating margin							
UnitedHealthcare	5.0%	5.2%	4.9%	(0.2)%		0.3%	
OptumHealth	10.1	8.9	8.4	1.2		0.5	
OptumInsight	24.9	21.9	20.6	3.0		1.3	
OptumRx	5.1	4.9	4.4	0.2		0.5	
Optum	8.1	7.4	6.7	0.7		0.7	
Consolidated operating margin	7.7%	7.6%	7.0%	0.1%		0.6%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
UnitedHealthcare Employer & Individual	$ 54,761	$ 52,066	$ 53,084	$ 2,695	5%	$ (1,018)	(2)%
UnitedHealthcare Medicare & Retirement	75,473	65,995	56,329	9,478	14	9,666	17
UnitedHealthcare Community & State	43,426	37,443	32,945	5,983	16	4,498	14
UnitedHealthcare Global	9,816	7,753	6,223	2,063	27	1,530	25
Total UnitedHealthcare revenues	$183,476	$163,257	$148,581	$20,219	12%	$14,676	10%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2018	2017	2016	Change 2018 vs. 2017		Change 2017 vs. 2016	
Commercial:							
Risk-based	8,495	8,420	8,820	75	1%	(400)	(5)%
Fee-based	18,420	18,595	18,900	(175)	(1)	(305)	(2)
Fee-based TRICARE	—	2,850	2,860	(2,850)	(100)	(10)	—
Total commercial	26,915	29,865	30,580	(2,950)	(10)	(715)	(2)
Medicare Advantage	4,945	4,430	3,630	515	12	800	22
Medicaid	6,450	6,705	5,890	(255)	(4)	815	14
Medicare Supplement (Standardized)	4,545	4,445	4,265	100	2	180	4
Total public and senior	15,940	15,580	13,785	360	2	1,795	13
Total UnitedHealthcare — domestic medical	42,855	45,445	44,365	(2,590)	(6)	1,080	2
International	6,220	4,080	4,220	2,140	52	(140)	(3)
Total UnitedHealthcare — medical	49,075	49,525	48,585	(450)	(1)%	940	2%
Supplemental Data:							
Medicare Part D stand-alone	4,710	4,940	4,930	(230)	(5)%	10	—%

The overall increase in people served through risk-based benefit plans in the commercial group market was due to growth in services to small groups. Fee-based commercial group business declined primarily due to customers converting their retirees to Medicare Advantage plans, as well as certain customers expanding the number of carriers and reconfiguring geographies served. Medicare Advantage increased year-over-year due to growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by states adding new carriers to existing programs, reduced enrollment from state efforts to manage eligibility status and the sale of our New Mexico Medicaid plan. Medicare Supplement growth reflected strong customer retention and new sales. International growth was primarily driven by an acquisition in the first quarter.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served across its risk-based businesses, a higher revenue membership mix, rate increases for underlying medical cost trends and the impact of the return of the Health Insurance Industry Tax. UnitedHealthcare's operating margin decreased slightly due to the performance of our traditional community-based TANF Medicaid business.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below, as well as productivity and overall cost management initiatives.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery and behavioral health, digital consumer engagement and health financial services.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in data analytics product and service offerings and managed services as well as organic and acquisition-related growth in advisory services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to growth in specialty pharmacy, home delivery services, and overall prescription growth. OptumRx fulfilled 1,343 million and 1,298 million adjusted scripts in 2018 and 2017, respectively.

2017 RESULTS OF OPERATIONS COMPARED TO 2016 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by organic growth in the number of individuals served across our UnitedHealthcare benefits businesses and growth across the Optum business. The increase was partially offset by revenue decreases due to the withdrawals of the ACA-compliant products in the individual market and the effects of the Health Insurance Industry Tax moratorium.

Medical Costs and MCR

Medical costs increased due to risk-based membership growth and medical cost trends. The MCR increased due to the effects of the Health Insurance Industry Tax moratorium, offset primarily by the reduction in individual ACA business, medical management initiatives and an increase in favorable medical cost reserve development.

Income Tax Rate

Our effective tax rate decreased primarily due to the impact of Tax Reform and the Health Insurance Tax moratorium. The provision for income taxes included a $1.2 billion benefit from the revaluation of net deferred tax liabilities.

Reportable Segments

UnitedHealthcare

UnitedHealthcare's revenue increase was due to growth in the number of individuals served across its businesses and price increases for underlying medical cost trends, which were partially offset by the reduction of people served in ACA-compliant individual products and the impact of the Health Insurance Industry Tax moratorium.

The increase in UnitedHealthcare's earnings from operations was led by diversified growth and increased operating margin. The 2016 results included losses in ACA-compliant individual products and guaranty fund assessments.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below.

The results by segment were as follows:

OptumHealth

Revenue and earnings from operations increased at OptumHealth primarily due to organic and acquisition-related growth in care delivery.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in revenue management services and business process services.

OptumRx

Revenue and earnings from operations at OptumRx increased primarily due to client and consumer growth. In 2017, OptumRx fulfilled 1.3 billion adjusted scripts compared to 1.2 billion in 2016.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies.

In both 2018 and 2017, our U.S. regulated subsidiaries paid their parent companies dividends of $3.7 billion. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2018	2017	2016	Change 2018 vs. 2017	Change 2017 vs. 2016
Sources of cash:					
Cash provided by operating activities	$ 15,713	$ 13,596	$ 9,795	$ 2,117	$ 3,801
Issuances of long-term debt and commercial paper, net of repayments	4,134	—	990	4,134	(990)
Proceeds from common share issuances	838	688	429	150	259
Customer funds administered	—	3,172	1,692	(3,172)	1,480
Other	—	—	37	—	(37)
Total sources of cash	20,685	17,456	12,943		
Uses of cash:					
Cash paid for acquisitions, net of cash assumed	(5,997)	(2,131)	(1,760)	(3,866)	(371)
Cash dividends paid	(3,320)	(2,773)	(2,261)	(547)	(512)
Common share repurchases	(4,500)	(1,500)	(1,280)	(3,000)	(220)
Repayments of long-term debt and commercial paper, net of issuances	—	(2,615)	—	2,615	(2,615)
Purchases of property, equipment and capitalized software	(2,063)	(2,023)	(1,705)	(40)	(318)
Purchases of investments, net of sales and maturities	(4,099)	(4,319)	(5,927)	220	1,608
Other	(1,743)	(539)	(581)	(1,204)	42
Total uses of cash	(21,722)	(15,900)	(13,514)		
Effect of exchange rate changes on cash and cash equivalents	(78)	(5)	78	(73)	(83)
Net (decrease) increase in cash and cash equivalents	$ (1,115)	$ 1,551	$ (493)	$ (2,666)	$ 2,044

2018 Cash Flows Compared to 2017 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings in 2018 and the impact to 2017 cash flows from operating activities due to a change in net deferred tax liabilities from Tax Reform, partially offset by changes in working capital accounts.

Other significant changes in sources or uses of cash year-over-year included net issuances of debt in 2018 compared to net repayments in 2017, an increase in cash paid for acquisitions, increased share repurchases and a decrease in customer funds administered due to the timing of government payments.

2017 Cash Flows Compared to 2016 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings and changes in working capital accounts, partially offset by the change in net deferred tax liabilities driven by tax reform.

Other significant changes in sources or uses of cash year-over-year included net repayments of debt compared to 2016 net proceeds from debt issuances, which were partially offset by lower net purchases of investments.

Financial Condition

As of December 31, 2018, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $44.7 billion included $10.9 billion of cash and cash equivalents (of which $925 million was

available for general corporate use), $31.9 billion of debt securities and $2.0 billion of investments in equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.3 years and a weighted-average credit rating of "Double A" as of December 31, 2018. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%. As of December 31, 2018, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 38%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements and Supplementary Data."

Credit Ratings. Our credit ratings as of December 31, 2018 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	A-	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2018, we had Board authorization to purchase up to 94 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Dividends. In June 2018, our Board increased our annual cash dividend rate to shareholders to $3.60 per share from $3.00 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2018, under our various contractual obligations and commitments:

(in millions)	2019	2020 to 2021	2022 to 2023	Thereafter	Total
Debt (a)	$ 3,463	$ 8,970	$ 7,396	$ 37,988	$ 57,817
Operating leases	669	1,103	761	1,343	3,876
Purchase and other obligations (b)	1,216	2,205	808	175	4,404
Other liabilities (c)	1,206	260	257	5,213	6,936
Redeemable noncontrolling interests (d)	1,276	380	25	227	1,908
Total contractual obligations	$ 7,830	$ 12,918	$ 9,247	$ 44,946	$ 74,941

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty and remaining capital commitments for venture capital funds and other funding commitments. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2018.

(c) Includes obligations associated with contingent consideration and payments related to business acquisitions, certain employee benefit programs, amounts accrued for guaranty fund assessments, unrecognized tax benefits, and various long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions, future settlements, unrecognized tax benefits and other liabilities have been classified as "Thereafter."

(d) Includes commitments for redeemable shares of our subsidiaries. When the timing of the redemption is indeterminable, the commitment has been classified as "Thereafter."

Pending Acquisitions. In December 2017, we entered into an agreement to acquire a company in the health care sector for a total of approximately $4.3 billion, which is not reflected in the table above.

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2018, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements and Supplementary Data" for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2018, our days outstanding in medical payables was 50 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2018, 2017 and 2016 included favorable medical cost development related to prior years of $320 million, $690 million and $220 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim inventory levels and claim processing backlogs, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2018:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 550
(0.50)	366
(0.25)	182
0.25	(181)
0.50	(362)
0.75	(541)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and

mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2018:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 703
2	469
1	234
(1)	(234)
(2)	(469)
(3)	(703)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2018; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2018 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2018 net earnings would have increased or decreased by approximately $140 million.

For more detail related to our medical cost estimates, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Revenues

We derive a substantial portion of our revenues from health care insurance premiums. We recognize premium revenues in the period eligible individuals are entitled to receive health care services. Customers are typically billed monthly at a contracted rate per eligible person multiplied by the total number of people eligible to receive services.

Our Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under the CMS risk adjustment payment methodology. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. We estimate risk adjustment revenues based upon the data submitted and expected to be submitted to CMS. As a result of the variability of factors that determine such estimations, the actual amount of CMS’ retroactive payments could be materially more or less than our estimates. This may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability. For more detail on premium revenues, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.” Risk adjustment data for our plans is subject to review by the federal and state governments, including audit by regulators. See Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for additional information regarding these audits. Our estimates of premiums to be recognized are reduced by any expected premium minimum MLR rebates payable by us.

Goodwill and Intangible Assets

Goodwill. We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change that indicate the carrying value may not be recoverable. When testing goodwill for

impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: customer and/or membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the “Medical Cost Trend” section of Executive Overview-Business Trends and the “Medical Costs Payable” critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units’ operations could cause these assumptions to change in the future. As of October 1, 2018, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

Intangible Assets. Our finite-lived intangible assets are subject to impairment tests when events or circumstances indicate that an asset’s (or asset group’s) carrying value may exceed its estimated fair value. Consideration is given on a quarterly basis to a number of potential impairment indicators, including: changes in the use of the assets, changes in legal or other business factors that could affect value, experienced or expected operating cash-flow deterioration or losses, adverse changes in customer populations, adverse competitive or technological advances that could impact value and other factors.

Our indefinite-lived intangible assets are tested for impairment on an annual basis, or more frequently if impairment indicators exist. To determine if an indefinite-lived intangible asset is impaired, we compare its

estimated fair value to its carrying value. If the carrying value exceeds its estimated fair value, an impairment would be recorded for the amount by which the carrying value exceeds its estimated fair value. Intangible assets were not impaired in 2018.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers that constitute our client base. As of December 31, 2018, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2018, we had $14 billion of financial assets on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also as of December 31, 2018, $9 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2018, $30 billion of our investments were fixed-rate debt securities and $32 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2018 and 2017 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2018			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 276	$ 189	$ (2,242)	$ (5,017)
1	138	94	(1,140)	(2,724)
(1)	(138)	(94)	1,118	3,155
(2)	(276)	(189)	2,196	6,953

	December 31, 2017			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Financial Assets (b)	Fair Value of Financial Liabilities
2%	$ 300	$ 170	$ (1,958)	$ (4,546)
1	150	85	(933)	(2,460)
(1)	(150)	(85)	950	2,923
(2)	(197)	(133)	1,773	6,414

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2017, the assumed hypothetical change in interest rates does not reflect the full 200 basis point reduction in interest income or interest expense in 2017, as the rate cannot fall below zero.

(b) As of December 31, 2018 and 2017, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2018, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $600 million and $1.4 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2018, we had $2.0 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 12, 2019 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinions

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/S/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 10,866	$ 11,981
Short-term investments	3,458	3,509
Accounts receivable, net of allowances of $712 and $641	11,388	9,568
Other current receivables, net of allowances of $502 and $440	6,862	6,262
Assets under management	3,032	3,101
Prepaid expenses and other current assets	3,086	2,663
Total current assets	38,692	37,084
Long-term investments	32,510	28,341
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $4,141 and $3,694	8,458	7,013
Goodwill	58,910	54,556
Other intangible assets, net of accumulated amortization of $4,592 and $4,309	9,325	8,489
Other assets	4,326	3,575
Total assets	$ 152,221	$ 139,058
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 19,891	$ 17,871
Accounts payable and accrued liabilities	16,705	15,180
Commercial paper and current maturities of long-term debt	1,973	2,857
Unearned revenues	2,396	2,269
Other current liabilities	12,244	12,286
Total current liabilities	53,209	50,463
Long-term debt, less current maturities	34,581	28,835
Deferred income taxes	2,474	2,182
Other liabilities	5,730	5,556
Total liabilities	95,994	87,036
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,908	2,189
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings	55,846	48,730
Accumulated other comprehensive loss	(4,160)	(2,667)
Nonredeemable noncontrolling interests	2,623	2,057
Total equity	54,319	49,833
Total liabilities, redeemable noncontrolling interests and equity	$ 152,221	$ 139,058

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Premiums	$178,087	$158,453	$144,118
Products	29,601	26,366	26,658
Services	17,183	15,317	13,236
Investment and other income	1,376	1,023	828
Total revenues	226,247	201,159	184,840
Operating costs:			
Medical costs	145,403	130,036	117,038
Operating costs	34,074	29,557	28,401
Cost of products sold	26,998	24,112	24,416
Depreciation and amortization	2,428	2,245	2,055
Total operating costs	208,903	185,950	171,910
Earnings from operations	17,344	15,209	12,930
Interest expense	(1,400)	(1,186)	(1,067)
Earnings before income taxes	15,944	14,023	11,863
Provision for income taxes	(3,562)	(3,200)	(4,790)
Net earnings	12,382	10,823	7,073
Earnings attributable to noncontrolling interests	(396)	(265)	(56)
Net earnings attributable to UnitedHealth Group common shareholders	$ 11,986	$ 10,558	$ 7,017
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 12.45	$ 10.95	$ 7.37
Diluted	$ 12.19	$ 10.72	$ 7.25
Basic weighted-average number of common shares outstanding	963	964	952
Dilutive effect of common share equivalents	20	21	16
Diluted weighted-average number of common shares outstanding	983	985	968
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	6	5	3

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2018	2017	2016
Net earnings	$12,382	$10,823	$7,073
Other comprehensive (loss) income:			
Gross unrealized (losses) gains on investment securities during the period	(294)	209	(73)
Income tax effect	67	(72)	26
Total unrealized (losses) gains, net of tax	(227)	137	(47)
Gross reclassification adjustment for net realized gains included in net earnings	(62)	(83)	(166)
Income tax effect	14	30	60
Total reclassification adjustment, net of tax	(48)	(53)	(106)
Total foreign currency translation (losses) gains	(1,242)	(70)	806
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	10,865	10,837	7,726
Comprehensive income attributable to noncontrolling interests	(396)	(265)	(56)
Comprehensive income attributable to UnitedHealth Group common shareholders	$10,469	$10,572	$7,670

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation (Losses) Gains	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2016	953	$ 10	$ 29	$37,125	$ 56	$ (3,390)	$ (105)	$33,725
Adjustment to adopt ASU 2016-09				28				28
Net earnings				7,017			40	7,057
Other comprehensive (loss) income					(153)	806		653
Issuances of common stock, and related tax effects	9	—	191					191
Share-based compensation			455					455
Common share repurchases	(10)	—	(316)	(964)				(1,280)
Cash dividends paid on common shares ($2.375 per share)				(2,261)				(2,261)
Acquisition of redeemable noncontrolling interest shares			(143)					(143)
Redeemable noncontrolling interest fair value and other adjustments			(216)					(216)
Distributions to nonredeemable noncontrolling interest							(32)	(32)
Balance at December 31, 2016	952	10	—	40,945	(97)	(2,584)	(97)	38,177
Net earnings				10,558			194	10,752
Other comprehensive income (loss)					84	(70)		14
Issuances of common stock, and related tax effects	26	—	2,225					2,225
Share-based compensation			582					582
Common share repurchases	(9)	—	(1,500)					(1,500)
Cash dividends paid on common shares ($2.875 per share)				(2,773)				(2,773)
Acquisition of redeemable noncontrolling interest shares			283					283
Redeemable noncontrolling interest fair value and other adjustments			113					113
Acquisition of nonredeemable noncontrolling interests							2,112	2,112
Distributions to nonredeemable noncontrolling interest							(152)	(152)
Balance at December 31, 2017	969	10	1,703	48,730	(13)	(2,654)	2,057	49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				11,986			273	12,259
Other comprehensive loss					(275)	(1,242)		(1,517)
Issuances of common stock, and related tax effects	10	—	814					814
Share-based compensation			620					620
Common share repurchases	(19)	—	(2,974)	(1,526)				(4,500)
Cash dividends paid on common shares ($3.45 per share)				(3,320)				(3,320)
Redeemable noncontrolling interests fair value and other adjustments			(163)					(163)
Acquisition of nonredeemable noncontrolling interests							521	521
Distributions to nonredeemable noncontrolling interests							(228)	(228)
Balance at December 31, 2018	960	$ 10	$ —	$55,846	$ (264)	$ (3,896)	$ 2,623	$54,319

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2018	2017	2016
Operating activities			
Net earnings	$12,382	$10,823	$ 7,073
Noncash items:			
Depreciation and amortization	2,428	2,245	2,055
Deferred income taxes	42	(965)	81
Share-based compensation	638	597	485
Other, net	(71)	217	(82)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(1,351)	(1,062)	(1,357)
Other assets	(750)	(630)	(1,601)
Medical costs payable	1,831	1,284	1,849
Accounts payable and other liabilities	526	930	1,494
Unearned revenues	38	157	(202)
Cash flows from operating activities	15,713	13,596	9,795
Investing activities			
Purchases of investments	(14,010)	(14,588)	(17,547)
Sales of investments	3,641	4,623	7,339
Maturities of investments	6,270	5,646	4,281
Cash paid for acquisitions, net of cash assumed	(5,997)	(2,131)	(1,760)
Purchases of property, equipment and capitalized software	(2,063)	(2,023)	(1,705)
Other, net	(226)	(126)	37
Cash flows used for investing activities	(12,385)	(8,599)	(9,355)
Financing activities			
Common share repurchases	(4,500)	(1,500)	(1,280)
Cash dividends paid	(3,320)	(2,773)	(2,261)
Proceeds from common stock issuances	838	688	429
Repayments of long-term debt	(2,600)	(4,398)	(2,596)
Repayments of commercial paper, net	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt	6,935	5,291	3,968
Customer funds administered	(131)	3,172	1,692
Other, net	(1,386)	(413)	(581)
Cash flows used for financing activities	(4,365)	(3,441)	(1,011)
Effect of exchange rate changes on cash and cash equivalents	(78)	(5)	78
(Decrease) increase in cash and cash equivalents	(1,115)	1,551	(493)
Cash and cash equivalents, beginning of period	11,981	10,430	10,923
Cash and cash equivalents, end of period	$10,866	$11,981	$10,430
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,410	$ 1,133	$ 1,055
Cash paid for income taxes	3,257	4,004	4,726
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ 2,164	$ —

See Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets and estimates of other current liabilities and other current receivables. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, that fall below certain targets are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star ratings.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions

premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. 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 premium revenues based upon the diagnosis data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and compounding pharmacy facilities. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's mail-service pharmacy. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed through the retail network or received by consumers through the Company's mail-service pharmacy. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. 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 premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues that are recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2018 and 2017, accounts receivables related to products and services were $3.9 billion and $3.7 billion, respectively. In 2018 and 2017, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2018 or 2017.

For the years ended December 31, 2018 and 2017, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts that have an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 13 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2018.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims that have not been received or fully processed, using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized 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 security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of 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, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement, AARP Program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable

contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2018 and 2017, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $4.2 billion and $3.8 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2018.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2018.

Other Current Liabilities

Other current liabilities include health savings account deposits ($7.5 billion and $6.4 billion as of December 31, 2018 and 2017, respectively), deposits under the Medicare Part D program, the RSF associated with the AARP Program, accruals for premium rebate payments under the ACA, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2018 and 2017:

(in millions)	2018	2017
Redeemable noncontrolling interests, beginning of period	$2,189	$2,012
Net earnings	123	71
Acquisitions	102	565
Redemptions	(90)	(309)
Distributions	(53)	(38)
Fair value and other adjustments	(363)	(112)
Redeemable noncontrolling interests, end of period	$1,908	$2,189

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over two to five years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options and SARs vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options and SARs is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, SARs, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A one year moratorium on the collection of the Health Insurance Industry Tax will occur in 2019.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets.

Recently Issued Accounting Standards

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11 and 2018-20 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, the Company elected to not recognize lease assets and lease liabilities and expense the leases over a straight-line basis for the term of those leases. ASU 2016-02 requires new disclosures that depict the amount, timing and uncertainty of cash flows pertaining to an entity's leases. The Company adopted ASU 2016-02 on January 1, 2019, using the cumulative effect upon adoption approach. The adoption resulted in no material impact to the Company's balance sheet, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" (ASU 2016-01). Most notably, the new guidance requires that equity investments, with certain exemptions, be measured at fair value with changes in fair value recognized in net income as opposed to other comprehensive income. The Company adopted ASU 2016-01 on a prospective basis effective January 1, 2018, as required, and reclassified $24 million from accumulated other comprehensive income to retained earnings.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,434	$ 13	$ (42)	$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities — available-for-sale	32,240	101	(443)	31,898
Debt securities — held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities — held-to-maturity	621	1	(2)	620
Total debt securities	$ 32,861	$ 102	$ (445)	$ 32,518
December 31, 2017				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,673	$ 1	$ (30)	$ 2,644
State and municipal obligations	7,596	99	(35)	7,660
Corporate obligations	13,181	57	(44)	13,194
U.S. agency mortgage-backed securities	3,942	7	(38)	3,911
Non-U.S. agency mortgage-backed securities	1,018	3	(6)	1,015
Total debt securities — available-for-sale	28,410	167	(153)	28,424
Debt securities — held-to-maturity:				
U.S. government and agency obligations	254	1	(1)	254
State and municipal obligations	2	—	—	2
Corporate obligations	280	—	—	280
Total debt securities — held-to-maturity	536	1	(1)	536
Total debt securities	$ 28,946	$ 168	$ (154)	$ 28,960

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2018.

The Company held $2.0 billion of equity securities as of December 31, 2018 and December 31, 2017. The Company's investments in equity securities primarily consist of employee savings plan related investments, Brazilian real denominated fixed-income funds and dividend paying stocks, with readily determinable fair values. Additionally, the Company's investments included $1.5 billion and $0.9 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2018 and 2017, respectively.

The amortized cost and fair value of debt securities as of December 31, 2018, by contractual maturity, were as follows:

(in millions)	Available-for-Sale		Held-to-Maturity	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,560	$ 3,551	$ 150	$150
Due after one year through five years	12,432	12,297	213	212
Due after five years through ten years	7,362	7,270	129	129
Due after ten years	2,563	2,570	129	129
U.S. agency mortgage-backed securities	4,947	4,852	—	—
Non-U.S. agency mortgage-backed securities	1,376	1,358	—	—
Total debt securities	$32,240	$31,898	$ 621	$620

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2018						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 998	$ (7)	$ 1,425	$ (35)	$ 2,423	$ (42)
State and municipal obligations	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities	622	(7)	459	(13)	1,081	(20)
Total debt securities — available-for-sale	$12,355	$ (156)	$11,002	$ (287)	$23,357	$ (443)
December 31, 2017						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,249	$ (8)	$ 1,027	$ (22)	$ 2,276	$ (30)
State and municipal obligations	2,599	(21)	866	(14)	3,465	(35)
Corporate obligations	5,901	(23)	1,242	(21)	7,143	(44)
U.S. agency mortgage-backed securities	1,657	(12)	1,162	(26)	2,819	(38)
Non-U.S. agency mortgage-backed securities	411	(3)	144	(3)	555	(6)
Total debt securities — available-for-sale	$11,817	$ (67)	$ 4,441	$ (86)	$16,258	$ (153)

The Company's unrealized losses from all securities as of December 31, 2018 were generated from approximately 19,000 positions out of a total of 31,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of December 31, 2018, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety 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.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

There was no transfers in or out of Level 3 financial assets or liabilities during the year ended December 31, 2018 or 2017.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the year ended December 31, 2018 or 2017.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. 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 third-party pricing service (pricing service), which generally uses quoted 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 nonbinding 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.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds are estimated using valuation techniques that rely heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2018				
Cash and cash equivalents	$ 10,757	$ 109	$ —	$10,866
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities	—	1,358	—	1,358
Total debt securities — available-for-sale	3,099	28,626	173	31,898
Equity securities	1,832	13	—	1,845
Assets under management	1,086	1,938	8	3,032
Total assets at fair value	$ 16,774	$ 30,686	$ 181	$47,641
Percentage of total assets at fair value	35%	65%	—%	100%
December 31, 2017				
Cash and cash equivalents	$ 11,718	$ 263	$ —	$11,981
Debt securities — available-for-sale:				
U.S. government and agency obligations	2,428	216	—	2,644
State and municipal obligations	—	7,660	—	7,660
Corporate obligations	65	12,989	140	13,194
U.S. agency mortgage-backed securities	—	3,911	—	3,911
Non-U.S. agency mortgage-backed securities	—	1,015	—	1,015
Total debt securities — available-for-sale	2,493	25,791	140	28,424
Equity securities	1,784	14	194	1,992
Assets under management	1,117	1,984	—	3,101
Total assets at fair value	$ 17,112	$ 28,052	$ 334	$45,498
Percentage of total assets at fair value	38%	61%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2018					
Debt securities — held-to-maturity	$ 260	$ 65	$ 295	$ 620	$ 621
Long-term debt and other financing obligations	$ —	$ 37,944	$ —	$ 37,944	$ 36,554
December 31, 2017					
Debt securities — held-to-maturity	$ 267	$ 4	$ 265	$ 536	$ 536
Long-term debt and other financing obligations	$ —	$ 34,504	$ —	$ 34,504	$ 31,542

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2018	December 31, 2017
Land and improvements	$ 566	$ 405
Buildings and improvements	4,470	3,664
Computer equipment	1,984	1,829
Furniture and fixtures	1,525	1,208
Less accumulated depreciation	(2,787)	(2,488)
Property and equipment, net	5,758	4,618
Capitalized software	4,054	3,601
Less accumulated amortization	(1,354)	(1,206)
Capitalized software, net	2,700	2,395
Total property, equipment and capitalized software, net	$ 8,458	$ 7,013

Depreciation expense for property and equipment for the years ended December 31, 2018, 2017 and 2016 was $924 million, $799 million and $698 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2018, 2017 and 2016 was $606 million, $550 million and $475 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2017	$ 23,854	$ 6,322	$ 4,449	$12,959	$ 47,584
Acquisitions	690	5,189	1,221	—	7,100
Foreign currency effects and adjustments, net	(60)	(23)	4	(49)	(128)
Balance at December 31, 2017	24,484	11,488	5,674	12,910	54,556
Acquisitions	2,723	471	106	1,881	5,181
Foreign currency effects and adjustments, net	(807)	(12)	(8)	—	(827)
Balance at December 31, 2018	$ 26,400	$ 11,947	$ 5,772	$14,791	$ 58,910

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

	December 31, 2018			December 31, 2017		
(in millions)	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$11,622	$ (3,908)	$7,714	$10,832	$ (3,743)	$7,089
Trademarks and technology	1,122	(512)	610	1,054	(432)	622
Trademarks and other indefinite-lived	745	—	745	561	—	561
Other	428	(172)	256	351	(134)	217
Total	$13,917	$ (4,592)	$9,325	$12,798	$ (4,309)	$8,489

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2018 Fair Value	2018 Weighted-Average Useful Life	2017 Fair Value	2017 Weighted-Average Useful Life
Customer-related	$1,355	17 years	$324	13 years
Trademarks and technology	122	4 years	367	11 years
Other	97	9 years	82	6 years
Total acquired finite-lived intangible assets	$1,574	16 years	$773	11 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2019	$889
2020	795
2021	724
2022	632
2023	593

Amortization expense relating to intangible assets for the years ended December 31, 2018, 2017 and 2016 was $898 million, $896 million and $882 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2018	2017	2016
Medical costs payable, beginning of period	$ 17,871	$ 16,391	$ 14,330
Acquisitions	339	83	—
Reported medical costs:			
Current year	145,723	130,726	117,258
Prior years	(320)	(690)	(220)
Total reported medical costs	145,403	130,036	117,038
Medical payments:			
Payments for current year	(127,155)	(113,811)	(101,696)
Payments for prior years	(16,567)	(14,828)	(13,281)
Total medical payments	(143,722)	(128,639)	(114,977)
Medical costs payable, end of period	$ 19,891	$ 17,871	$ 16,391

For the years ended December 31, 2018 and 2016, no individual factors significantly impacted medical cost reserve development. For the year ended December 31, 2017, medical cost reserve development was primarily driven by lower than expected health system utilization levels.

Medical costs payable included IBNR of $13.2 billion and $12.3 billion at December 31, 2018 and 2017, respectively. Substantially all of the IBNR balance as of December 31, 2018 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2018:

(in millions)	Net Incurred Medical Costs For the Years ended December 31,	
Year	2017	2018
2017	$ 130,726	$ 130,441
2018		145,723
Total		$ 276,164

(in millions)	Net Cumulative Medical Payments For the Years ended December 31,	
Year	2017	2018
2017	$ (113,811)	$ (129,778)
2018		(127,155)
Total		(256,933)
Net remaining outstanding liabilities prior to 2017		660
Total medical costs payable		$ 19,891

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2018			December 31, 2017		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ —	$ —	$ —	$ 150	$ 150	$ 150
6.000% notes due February 2018	—	—	—	1,100	1,101	1,106
1.900% notes due July 2018	—	—	—	1,500	1,499	1,501
1.700% notes due February 2019	750	750	749	750	749	747
1.625% notes due March 2019	500	500	499	500	501	497
2.300% notes due December 2019	500	494	497	500	495	501
2.700% notes due July 2020	1,500	1,498	1,494	1,500	1,496	1,517
Floating rate notes due October 2020	300	299	298	300	299	300
3.875% notes due October 2020	450	443	456	450	446	467
1.950% notes due October 2020	900	897	884	900	895	892
4.700% notes due February 2021	400	398	412	400	403	425
2.125% notes due March 2021	750	747	734	750	746	744
Floating rate notes due June 2021	350	349	347	—	—	—
3.150% notes due June 2021	400	399	400	—	—	—
3.375% notes due November 2021	500	489	503	500	493	516
2.875% notes due December 2021	750	735	748	750	741	760
2.875% notes due March 2022	1,100	1,051	1,091	1,100	1,054	1,114
3.350% notes due July 2022	1,000	997	1,005	1,000	996	1,033
2.375% notes due October 2022	900	894	872	900	893	891
0.000% notes due November 2022	15	12	13	15	12	12
2.750% notes due February 2023	625	602	611	625	606	626
2.875% notes due March 2023	750	750	739	750	762	759
3.500% notes due June 2023	750	746	756	—	—	—
3.500% notes due February 2024	750	745	755	—	—	—
3.750% notes due July 2025	2,000	1,989	2,025	2,000	1,987	2,108
3.700% notes due December 2025	300	298	303	—	—	—
3.100% notes due March 2026	1,000	995	965	1,000	995	1,007
3.450% notes due January 2027	750	746	742	750	745	776
3.375% notes due April 2027	625	619	611	625	618	642
2.950% notes due October 2027	950	938	898	950	937	947
3.850% notes due June 2028	1,150	1,142	1,163	—	—	—
3.875% notes due December 2028	850	842	861	—	—	—
4.625% notes due July 2035	1,000	992	1,060	1,000	991	1,165
5.800% notes due March 2036	850	838	1,003	850	837	1,105
6.500% notes due June 2037	500	492	638	500	491	698
6.625% notes due November 2037	650	641	841	650	641	923
6.875% notes due February 2038	1,100	1,076	1,437	1,100	1,075	1,596
5.700% notes due October 2040	300	296	355	300	296	389
5.950% notes due February 2041	350	345	426	350	345	466
4.625% notes due November 2041	600	588	627	600	588	685
4.375% notes due March 2042	502	484	503	502	483	555
3.950% notes due October 2042	625	607	596	625	607	650
4.250% notes due March 2043	750	734	744	750	734	822
4.750% notes due July 2045	2,000	1,973	2,116	2,000	1,972	2,362
4.200% notes due January 2047	750	738	745	750	738	808
4.250% notes due April 2047	725	717	719	725	717	798
3.750% notes due October 2047	950	933	869	950	933	969
4.250% notes due June 2048	1,350	1,329	1,349	—	—	—
4.450% notes due December 2048	1,100	1,087	1,132	—	—	—
Total commercial paper and long-term debt	$35,667	$35,234	$36,591	$31,417	$31,067	$34,029

The Company's long-term debt obligations also included $1.3 billion and $625 million of other financing obligations, of which $229 million and $107 million were current as of December 31, 2018 and 2017, respectively.

Maturities of long-term debt for the years ending December 31 are as follows:

(in millions)	
2019	$ 1,973
2020	3,350
2021	3,350
2022	3,215
2023	2,325
Thereafter	22,775

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

The Company has $3.5 billion five-year, $3.5 billion three-year and $3.0 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2023, December 2021 and December 2019, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2018, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2018, annual interest rates would have ranged from 3.2% to 3.6%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2018.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2018	2017	2016
Current Provision:			
Federal	$2,897	$3,597	$4,302
State and local	219	314	312
Foreign	404	254	95
Total current provision	3,520	4,165	4,709
Deferred provision (benefit)	42	(965)	81
Total provision for income taxes	$3,562	$3,200	$4,790

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2018		2017		2016	
Tax provision at the U.S. federal statutory rate	$3,348	21.0%	$4,908	35.0%	$4,152	35.0%
Change in tax law	—	—	(1,199)	(8.6)	—	—
State income taxes, net of federal benefit	168	1.0	197	1.4	205	1.7
Share-based awards — excess tax benefit	(161)	(1.0)	(319)	(2.3)	(158)	(1.3)
Non-deductible compensation	117	0.7	175	1.3	128	1.1
Health insurance industry tax	552	3.5	—	—	645	5.4
Foreign rate differential	(203)	(1.3)	(282)	(2.0)	(105)	(0.9)
Other, net	(259)	(1.6)	(280)	(2.0)	(77)	(0.6)
Provision for income taxes	$3,562	22.3%	$3,200	22.8%	$4,790	40.4%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2018	2017
Deferred income tax assets:		
Accrued expenses and allowances	$ 551	$ 544
U.S. federal and state net operating loss carryforwards	190	216
Share-based compensation	91	97
Nondeductible liabilities	184	169
Non-U.S. tax loss carryforwards	426	445
Other-domestic	306	167
Other-non-U.S.	337	198
Subtotal	2,085	1,836
Less: valuation allowances	(84)	(64)
Total deferred income tax assets	2,001	1,772
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,131)	(1,998)
Non-U.S. goodwill and intangible assets	(709)	(602)
Capitalized software	(603)	(530)
Depreciation and amortization	(266)	(236)
Prepaid expenses	(152)	(223)
Outside basis in partnerships	(300)	(279)
Other-non-U.S.	(314)	(86)
Total deferred income tax liabilities	(4,475)	(3,954)
Net deferred income tax liabilities	$(2,474)	$(2,182)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $99 million expire beginning in 2022 through 2037 and $17 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2019 through 2038. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2018, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2018	2017	2016
Gross unrecognized tax benefits, beginning of period	$ 598	$ 263	$ 224
Gross increases:			
Current year tax positions	487	356	37
Prior year tax positions	87	40	24
Gross decreases:			
Prior year tax positions	(84)	(33)	(4)
Settlements	(20)	(24)	(6)
Statute of limitations lapses	(12)	(4)	(12)
Gross unrecognized tax benefits, end of period	$1,056	$ 598	$ 263

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $118 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2018, 2017 and 2016, the Company recognized $6 million, $14 million and $11 million of interest and penalties, respectively. The Company had $95 million and $84 million of accrued interest and penalties for uncertain tax positions as of December 31, 2018 and 2017, respectively. These amounts are not included in the reconciliation above. As of December 31, 2018, there were $716 million of unrecognized tax benefits that, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2018 and 2017 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2012 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2013 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries in the United States are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For both the years ended December 31, 2018 and 2017, the Company's regulated subsidiaries paid their parent companies dividends of $3.7 billion, including $1.1 billion of extraordinary dividends.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of $23.7 billion as of December 31, 2018. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $10.3 billion as of December 31, 2018.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) to be considered "Well Capitalized" under the capital adequacy rules to which it is subject. At December 31, 2018, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2018 and 2017 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2018**	**2017**
Common share repurchases, shares	19	9
Common share repurchases, average price per share	$236.72	$173.54
Common share repurchases, aggregate cost	$ 4,500	$ 1,500
Board authorized shares remaining	94	42

Dividends

In June 2018, the Company's Board of Directors increased the Company's annual dividend rate to shareholders to $3.60 per share compared to $3.00 per share, which the Company had paid since June 2017. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options, SARs and restricted shares. As of December 31, 2018, the Company had 42 million shares available for future grants of share-based awards under the Plan. As of December 31, 2018, there were also 7 million shares of common stock available for issuance under the ESPP.

Stock Options and SARs

Stock option and SAR activity for the year ended December 31, 2018 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	37	$ 102		
Granted	7	229		
Exercised	(8)	78		
Forfeited	(1)	162		
Outstanding at end of period	35	131	6.5	$ 4,114
Exercisable at end of period	16	87	5.0	2,560
Vested and expected to vest, end of period	34	129	6.5	4,072

Restricted Shares

Restricted share activity for the year ended December 31, 2018 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	7	$ 128
Granted	2	229
Vested	(3)	119
Nonvested at end of period	6	163

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2018	2017	2016
Stock Options and SARs			
Weighted-average grant date fair value of shares granted, per share	$ 43	$ 29	$ 20
Total intrinsic value of stock options and SARs exercised	1,431	1,473	595
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	229	163	115
Total fair value of restricted shares vested	$ 521	$ 460	$274
Employee Stock Purchase Plan			
Number of shares purchased	2	2	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 638	$ 597	$485
Share-based compensation expense, net of tax effects	587	531	417
Income tax benefit realized from share-based award exercises	239	431	236

(in millions, except years)	December 31, 2018
Unrecognized compensation expense related to share awards	$ 628
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	For the Years Ended December 31,		
	2018	2017	2016
Risk-free interest rate	2.6% - 3.1%	1.9% - 2.1%	1.2% - 1.4%
Expected volatility	18.7% - 19.3%	18.5% - 20.7%	20.8% - 22.5%
Expected dividend yield	1.3% - 1.5%	1.4% - 1.6%	1.8%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.6	5.7	5.6 - 5.9

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option and SAR exercises and forfeitures within the valuation model. The expected lives of options and SARs granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2018, 2017 and 2016.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $988 million and $865 million as of December 31, 2018 and 2017, respectively.

12. Commitments and Contingencies

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. Rent expense under all operating leases for the years ended December 31, 2018, 2017 and 2016 was $751 million, $710 million and $608 million, respectively.

As of December 31, 2018, future minimum annual lease payments, net of sublease income, under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2019	$ 669
2020	592
2021	511
2022	423
2023	338
Thereafter	1,343

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2018, 2017 or 2016.

As of December 31, 2018, the Company had outstanding, undrawn letters of credit with financial institutions of $83 million and surety bonds outstanding with insurance companies of $1.3 billion, primarily to bond contractual performance.

Pending Acquisition

In December 2017, the Company entered into an agreement to acquire a company in the health care sector for a total of approximately $4.3 billion.

Legal Matters

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. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

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.

Government Investigations, Audits and Reviews

The Company has been involved 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, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

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 made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. Those motions were argued in September 2018. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

13. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits and health care delivery.
- *OptumHealth* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. OptumHealth serves the physical, emotional and health-related financial needs of individuals, enabling population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* provides services, technology and health care expertise to major participants in the health care industry. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and compounding pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 30%, 28% and 25% for 2018, 2017 and 2016, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 96%, 96% and 97% of consolidated total revenues for 2018, 2017 and 2016, respectively. Long-lived fixed assets located in the United States represented approximately 76% and 77% of the total long-lived fixed assets as of December 31, 2018 and 2017, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
2018								
Revenues — unaffiliated customers:								
Premiums	$ 174,282	$ 3,805	$ —	$ —	$ —	$ 3,805	$ —	$ 178,087
Products	—	52	111	29,438	—	29,601	—	29,601
Services	8,366	4,925	3,280	612	—	8,817	—	17,183
Total revenues — unaffiliated customers	182,648	8,782	3,391	30,050	—	42,223	—	224,871
Total revenues — affiliated customers	—	14,882	5,596	39,440	(1,409)	58,509	(58,509)	—
Investment and other income	828	481	21	46	—	548	—	1,376
Total revenues	$ 183,476	$ 24,145	$ 9,008	$ 69,536	$ (1,409)	$101,280	$ (58,509)	$ 226,247
Earnings from operations	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ —	$ 17,344
Interest expense	—	—	—	—	—	—	(1,400)	(1,400)
Earnings before income taxes	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ (1,400)	$ 15,944
Total assets	$ 82,938	$ 29,837	$ 11,039	$ 33,912	$ —	$ 74,788	$ (5,505)	$ 152,221
Purchases of property, equipment and capitalized software	761	593	517	192	—	1,302	—	2,063
Depreciation and amortization	845	439	654	490	—	1,583	—	2,428
2017								
Revenues — unaffiliated customers:								
Premiums	$ 154,709	$ 3,744	$ —	$ —	$ —	$ 3,744	$ —	$ 158,453
Products	—	44	106	26,216	—	26,366	—	26,366
Services	7,890	4,013	2,849	565	—	7,427	—	15,317
Total revenues — unaffiliated customers	162,599	7,801	2,955	26,781	—	37,537	—	200,136
Total revenues — affiliated customers	—	12,429	5,127	36,954	(1,227)	53,283	(53,283)	—
Investment and other income	658	340	5	20	—	365	—	1,023
Total revenues	$ 163,257	$ 20,570	$ 8,087	$ 63,755	$ (1,227)	$ 91,185	$ (53,283)	$ 201,159
Earnings from operations	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ —	$ 15,209
Interest expense	—	—	—	—	—	—	(1,186)	(1,186)
Earnings before income taxes	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ (1,186)	$ 14,023
Total assets	$ 76,676	$ 26,931	$ 11,273	$ 29,551	$ —	$ 67,755	$ (5,373)	$ 139,058
Purchases of property, equipment and capitalized software	737	510	588	188	—	1,286	—	2,023
Depreciation and amortization	758	380	614	493	—	1,487	—	2,245
2016								
Revenues — unaffiliated customers:								
Premiums	$ 140,455	$ 3,663	$ —	$ —	$ —	$ 3,663	$ —	$ 144,118
Products	1	48	103	26,506	—	26,657	—	26,658
Services	7,514	2,498	2,670	554	—	5,722	—	13,236
Total revenues — unaffiliated customers	147,970	6,209	2,773	27,060	—	36,042	—	184,012
Total revenues — affiliated customers	—	10,491	4,559	33,372	(1,088)	47,334	(47,334)	—
Investment and other income	611	208	1	8	—	217	—	828
Total revenues	$ 148,581	$ 16,908	$ 7,333	$ 60,440	$ (1,088)	$ 83,593	$ (47,334)	$ 184,840
Earnings from operations	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ —	$ 12,930
Interest expense	—	—	—	—	—	—	(1,067)	(1,067)
Earnings before income taxes	$ 7,307	$ 1,428	$ 1,513	$ 2,682	$ —	$ 5,623	$ (1,067)	$ 11,863
Total assets	$ 70,505	$ 18,656	$ 9,017	$ 29,066	$ —	$ 56,739	$ (4,434)	$ 122,810
Purchases of property, equipment and capitalized software	640	345	571	149	—	1,065	—	1,705
Depreciation and amortization	724	297	559	475	—	1,331	—	2,055

14. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2018 and 2017 is as follows:

(in millions, except per share data)	For the Quarter Ended March 31	June 30	September 30	December 31
2018				
Revenues	$ 55,188	$ 56,086	$ 56,556	$ 58,417
Operating costs	51,135	51,882	51,966	53,920
Earnings from operations	4,053	4,204	4,590	4,497
Net earnings	2,924	3,010	3,284	3,164
Net earnings attributable to UnitedHealth Group common shareholders	2,836	2,922	3,188	3,040
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.94	3.04	3.31	3.16
Diluted	2.87	2.98	3.24	3.10
2017				
Revenues	$ 48,723	$ 50,053	$ 50,322	$ 52,061
Operating costs	45,310	46,322	46,234	48,084
Earnings from operations	3,413	3,731	4,088	3,977
Net earnings	2,191	2,350	2,561	3,721
Net earnings attributable to UnitedHealth Group common shareholders	2,172	2,284	2,485	3,617
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.28	2.37	2.57	3.73
Diluted	2.23	2.32	2.51	3.65

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2018. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2018.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2018

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2018. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013).* Based on our assessment and the COSO criteria, we believe that, as of December 31, 2018, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2018, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2018, of the Company and our report dated February 12, 2019, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2018. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 12, 2019, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP

Richard T. Burke
Lead Independent Director
UnitedHealth Group

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Executive Chair
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie Montgomery Rice, M.D
President and Dean
Morehouse School of Medicine

Glenn M. Renwick
Chair
Fiserv, Inc.

David S. Wichmann
Chief Executive Officer
UnitedHealth Group

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402, 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and

"Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2018, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	33	$ 135	49[3]
Equity compensation plans not approved by shareholders [2]	—	—	—
Total [2]	33	$ 135	49

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.

(2) Excludes 1,676,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of $59 and an average remaining term of approximately 5 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 7 million shares of common stock available for future issuance under the 1993 Employee Stock Purchase Plan as of December 31, 2018, and 42 million shares available under the 2011 Stock Incentive Plan as of December 31, 2018. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, SARs, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2019 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements and Supplementary Data*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2018 and 2017.
- Consolidated Statements of Operations for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2018, 2017, and 2016.
- Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017, and 2016.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on August 16, 2017)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)

4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2018
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)

10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10(e) of UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2003)
*10.18	First Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 3, 2006)
*10.19	Second Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.20	Third Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.17 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.21	Fourth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014)
*10.23	Sixth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.24	Seventh Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 10.24 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2016)
*10.25	Eighth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement) (incorporated by reference to Exhibit 4.9 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-224254, filed on April 12, 2018)
*10.26	Summary of Non-Management Director Compensation, effective as of October 1, 2018

*10.27	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.28	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.29	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.30	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.31	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.32	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
*10.33	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.34	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.35	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.36	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.37	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.38	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.39	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.40	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)

*10.41	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.42	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.43	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.44	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.45	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)
*10.46	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.47	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.48	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.49	Amended and Restated Employment Agreement, effective as of March 24, 2015, between United HealthCare Services, Inc. and Steven H. Nelson (incorporated by reference to Exhibit 10.51 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2017)
*10.50	Employment Agreement, effective as of June 3, 2018, between United HealthCare Services, Inc. and Andrew Witty
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data")
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2018, filed on February 12, 2019, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets, (ii) Consolidated Statements of Operations, (iii) Consolidated Statements of Comprehensive Income, (iv) Consolidated Statements of Changes in Equity, (v) Consolidated Statements of Cash Flows, and (vi) Notes to the Consolidated Financial Statements.

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2018 and 2017, and for each of the three years in the period ended December 31, 2018, and the Company's internal control over financial reporting as of December 31, 2018, and have issued our reports thereon dated February 12, 2019; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 12, 2019

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 434	$ 359
Other current assets	197	575
Total current assets	631	934
Equity in net assets of subsidiaries	83,244	76,231
Long-term notes receivable from subsidiaries	4,461	4,278
Other assets	972	839
Total assets	$ 89,308	$ 82,282
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 618	$ 502
Current portion of notes payable to subsidiaries	714	466
Commercial paper and current maturities of long-term debt	1,744	2,749
Total current liabilities	3,076	3,717
Long-term debt, less current maturities	33,490	28,318
Long-term notes payable to subsidiaries	560	1,518
Other liabilities	486	953
Total liabilities	37,612	34,506
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value -10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 960 and 969 issued and outstanding	10	10
Additional paid-in capital	—	1,703
Retained earnings	55,846	48,730
Accumulated other comprehensive loss	(4,160)	(2,667)
Total UnitedHealth Group shareholders' equity	51,696	47,776
Total liabilities and shareholders' equity	$ 89,308	$ 82,282

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Investment and other income	$ 194	$ 527	$ 522
Total revenues	194	527	522
Operating costs:			
Operating costs	35	—	(22)
Interest expense	1,285	1,114	995
Total operating costs	1,320	1,114	973
Loss before income taxes	(1,126)	(587)	(451)
Benefit for income taxes	251	214	165
Loss of parent company	(875)	(373)	(286)
Equity in undistributed income of subsidiaries	12,861	10,931	7,303
Net earnings	11,986	10,558	7,017
Other comprehensive (loss) income	(1,517)	14	653
Comprehensive income	$10,469	$10,572	$7,670

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2018	2017	2016
Operating activities			
Cash flows from operating activities	$ 6,099	$ 2,021	$ 4,294
Investing activities			
Issuances of notes to subsidiaries	(1,420)	—	(824)
Repayments of notes to subsidiaries	1,419	2,071	—
Cash paid for acquisitions	(4,066)	(2,313)	(2,292)
Return of capital to parent company	4,196	3,375	2,143
Capital contributions to subsidiaries	(1,259)	(959)	(765)
Other, net	4	—	168
Cash flows (used for) from investing activities	(1,126)	2,174	(1,570)
Financing activities			
Common stock repurchases	(4,500)	(1,500)	(1,280)
Proceeds from common stock issuances	838	688	429
Cash dividends paid	(3,320)	(2,773)	(2,261)
Repayments of commercial paper, net	(201)	(3,508)	(382)
Proceeds from issuance of long-term debt	6,935	5,291	3,968
Repayments of long-term debt	(2,600)	(3,472)	(2,596)
(Repayments) proceeds of notes from subsidiary	(1,127)	1,704	(30)
Other, net	(923)	(446)	(421)
Cash flows used for financing activities	(4,898)	(4,016)	(2,573)
Increase in cash and cash equivalents	75	179	151
Cash and cash equivalents, beginning of period	359	180	29
Cash and cash equivalents, end of period	$ 434	$ 359	$ 180
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,294	$ 1,062	$ 974
Cash paid for income taxes	2,379	3,455	4,557
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ 2,164	$ —
Conversion of note receivable from subsidiaries to equity	—	4,378	—

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.6 billion, $3.4 billion and $3.7 billion in 2018, 2017 and 2016, respectively. Additionally, $4.2 billion, $3.4 billion and $2.1 billion in cash were received as a return of capital to the parent company during 2018, 2017 and 2016, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled $1.3 billion and $625 million at December 31, 2018 and 2017, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2019	$ 1,750
2020	3,150
2021	3,150
2022	3,015
2023	2,125
Thereafter	22,477

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 12, 2019

UNITEDHEALTH GROUP INCORPORATED

By /s/ DAVID S. WICHMANN

David S. Wichmann
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ DAVID S. WICHMANN **David S. Wichmann**	Director and Chief Executive Officer (principal executive officer)	February 12, 2019
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 12, 2019
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 12, 2019
* **William C. Ballard, Jr.**	Director	February 12, 2019
* **Richard T. Burke**	Director	February 12, 2019
* **Timothy P. Flynn**	Director	February 12, 2019
* **Stephen J. Hemsley**	Director	February 12, 2019
* **Michele J. Hooper**	Director	February 12, 2019
* **F. William McNabb III**	Director	February 12, 2019
* **Valerie Montgomery Rice**	Director	February 12, 2019
* **Glenn M. Renwick**	Director	February 12, 2019
* **Gail R. Wilensky**	Director	February 12, 2019

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2019

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Delaware	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large Accelerated Filer ☒
Non-accelerated filer ☐
Accelerated filer ☐
Smaller reporting company ☐
Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 28, 2019 was $229,868,010,278 (based on the last reported sale price of $244.01 per share on June 28, 2019, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 31, 2020, there were 948,573,372 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2020 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in data and health information, advanced technology, and clinical expertise, focused on improving health outcomes, lowering health care costs and creating a better experience for patients, their caregivers and physicians. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

Through UnitedHealthcare and Optum, in 2019, we processed nearly a trillion dollars in gross billed charges and we managed more than $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology, consulting and managed outsourced services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- strong local-market relationships;
- the breadth of product offerings, based upon extensive expertise in distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate and provide patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler and more satisfying consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1.4 million physicians and other health care professionals and more than 6,500 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. UnitedHealthcare Employer & Individual provides access to medical services for 27.8 million people on behalf of our customers and alliance partners, including employer customers, serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings. We also offer and have been developing a variety of innovative consumer-centric products that align to the unique needs and financial means of our customers, while engaging individuals in better managing their health.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products, which complement its service offerings by improving quality of care, engaging consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;

- mental health/substance use disorder management; and
- employee assistance programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing, life, transportation, critical illness, specified disease/sickness, accident and short-term disability product offerings using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people choice in obtaining the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and health system navigator services, clinical management programs, nurse health line services, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through agents, employer groups and digital channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 5.3 million people through its Medicare Advantage products as of December 31, 2019.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below that of traditional Medicare, while helping seniors live healthier lives. Through our HouseCalls program, nurse practitioners performed 1.7 million in-home preventive care visits in 2019 to address unmet care opportunities and close gaps in care. Our Navigate4Me program

provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software and digital therapeutics for remote monitoring that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2019, UnitedHealthcare enrolled 9.0 million people in the Medicare Part D programs, including 4.4 million individuals in the stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.8 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

Premium revenues from CMS represented 33% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2019, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF), Children's Health Insurance Programs (CHIP), Dual SNPs (DSNPs), Long-Term Services and Supports (LTSS), Aged, Blind and Disabled and other federal, state and community health care programs. As of December 31, 2019, UnitedHealthcare Community & State participated in programs in 31 states and the District of Columbia, and served 5.9 million people; including nearly 1 million people through Medicaid expansion programs in 15 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants that can affect people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only 50% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care, including DSNP and LTSS programs. This expansion includes integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care; typically, the 5% who are most at risk drive over 50% of states' medical costs.

UnitedHealthcare Global

UnitedHealthcare Global serves nearly 8 million people with medical and dental benefits, residing principally in Brazil, Chile, Colombia and Peru, but also in more than 140 other countries. UnitedHealthcare Global serves multinational and local businesses, governments, insurers and individuals and their families through health insurance plans for local populations, care delivery services, benefit plans and risk and assistance solutions. UnitedHealthcare Global offers health care delivery in these markets through more than 300 hospitals, outpatient and ambulatory clinics and surgery centers to UnitedHealthcare Global members and consumers served by the external payer market.

In Brazil, Amil provides health benefits to 3.6 million people and dental benefits to 2.2 million people. Empresas Banmédica provides health benefits and health care services to 2.1 million people in Chile, Colombia and Peru. Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

Optum

Optum is a technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers, health plans, and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight offers data, analytics, research, consulting, technology and managed services solutions; and
- OptumRx provides a diversified array of pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of 96 million unique individuals. OptumHealth enables population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health and by coordinating care for the most medically complex patients.

OptumHealth serves patients and care providers through its local ambulatory care services business and delivers care through a physician-led, patient-centric and data-driven organization comprised of nearly 50,000 employed, managed or contracted physicians, helping improve care quality, affordability and patient experience. OptumHealth also enables care providers' transition from traditional, fee-for-service care delivery to performance-based delivery and payment models that improve the focus on patient health and outcomes, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies that improve the coordination of care across all providers involved in patient care to more comprehensively serve patients. Surgical Care Affiliates' independent ambulatory surgical centers and surgical hospitals provide high-value surgical services at a substantially lower cost than a traditional in-patient hospital setting and MedExpress' neighborhood care centers provide urgent and walk-in care services with a consumer-friendly approach.

OptumServe provides a wide range of health services specifically tailored to active military and veterans and the agencies that support them.

OptumHealth serves people through population health services that meet both the preventive care and health intervention needs of consumers across the care continuum, encompassing physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists, including behavioral health, organ transplant, chiropractic and physical therapy. OptumHealth engages consumers in managing their health through guidance, digital tools and programs that help them achieve their health goals and maintain healthy lifestyles.

Optum Financial Services, through Optum Bank, a wholly-owned subsidiary, serves consumers through 5.6 million health savings and other accounts and has nearly $12 billion in assets under management as of December 31, 2019. During 2019, Optum Bank processed $170 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served, or on a fee-for-service basis, where it delivers medical services to patients in exchange for a contracted fee. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, the Department of Defense, the Veterans Administration and other federal procurement agencies).

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on technology, research and consulting and managed services that help improve the quality of care and drive greater efficiency in the health care system. Technology includes population health and risk analytics, administrative and clinical technology for claims editing, risk adjustment and payment integrity, health information and electronic data exchange and technology strategy and management. Research and consulting helps organizations reduce administrative costs and implement best practices to improve clinical performance. Managed services provides solutions such as revenue cycle management, risk analytics, payment integrity outsourcing and state Medicaid data and technology management. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog as of December 31, 2019 was $19.3 billion, of which $9.9 billion is expected to be realized within the next 12 months. The aggregate backlog includes $7.1 billion related to affiliated agreements. OptumInsight's aggregate backlog as of December 31, 2018, was $17.0 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight believes it is well positioned to address the needs of four primary market segments: care providers (e.g., physicians and hospital systems), health plans, governments and life sciences companies.

Care Providers. Serving nine out of ten U.S. hospitals and more than 100,000 physicians, OptumInsight assists care providers in meeting their challenge to improve patient outcomes and care amid changing payment models and pressures. OptumInsight brings a broad array of solutions to help care providers meet these challenges, with particular focus on clinical performance and quality improvement, population health, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Health Plans. OptumInsight serves four out of five U.S. health plans through cost-effective, technology-enabled solutions that help them improve efficiency, understand and optimize growth while managing risk, improve payment integrity performance, deliver on clinical initiatives and compliance goals, and build and manage strong networks of care.

Governments. OptumInsight provides services tailored to government payers, including data and analytics technology, claims management and payment accuracy services, and strategic consulting.

Life Sciences. OptumInsight provides services to global life sciences companies. These companies look to OptumInsight for data, analytics and expertise in core areas of health economics and outcomes research, market access consulting, integrated clinical and health care claims data and informatics services, epidemiology and drug safety, and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to 56 million people in the United States through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and community health pharmacies and through the provision of infusion services. OptumRx manages limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology and serves the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2019, OptumRx managed $96 billion in pharmaceutical spending, including $40 billion in specialty pharmaceutical spending.

OptumRx provides pharmacy care services to a number of health plans, including a substantial majority of UnitedHealthcare members, large national employer plans, unions and trusts, purchasing coalitions and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs, digital tools and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner, which are designed to promote better health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events that affect member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care by using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and people served.

As of December 31, 2019, OptumRx operated seven home delivery pharmacies in the United States, which provide patients with access to maintenance medications and enables OptumRx to manage clients' drug costs through operating efficiencies and economies of scale. As of December 31, 2019, OptumRx's specialty pharmacy operations included nearly 70 specialty and infusion pharmacies located throughout the United States that are used for delivery of advanced medications to people with chronic or genetic diseases and disorders. OptumRx also operates more than 500 community mental health facility pharmacies, which help align benefits, care management and pharmacy services for those living with complex, chronic medical and behavioral health issues.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts that are subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriately reducing or limiting health care services, anti-money laundering, securities and antitrust compliance.

Privacy, Security and Data Standards Regulation. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

The Health Information Technology for Economic and Clinical Health Act (HITECH) regulates matters relating to privacy, security and data standards. HITECH imposes requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds federal data breach notification requirements for covered entities and business associates and reporting requirements to the U.S. Department of Health and Human Services (HHS) and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to “opt out” of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations that may apply to us, as discussed below. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations that is subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those that maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations that, where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by that state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports that describe capital structure, ownership, financial condition, certain affiliated transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material affiliated transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies that oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations that may affect our privacy and security practices, such as state laws that govern the use, disclosure and protection of social security numbers and protected health information or that are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from

identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies in the different states may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws that prohibit specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices that involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx's businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies that must be licensed as pharmacies in the states in which they are located. Certain of our home delivery, specialty and compounding pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our home delivery, specialty and compounding pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our home delivery, specialty and compounding pharmacies to follow the laws of the state in which the pharmacies are located, but some states also require us to comply with the laws of that non-resident state when pharmaceuticals are delivered there. Additionally, certain of our pharmacies that participate in programs for Medicare and state Medicaid providers are required to comply with the applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our home delivery and specialty pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards that impact PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to on-line communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure that the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure that the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions, which carries out annual examinations to ensure that the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve, which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, "Risk Factors" for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, UnitedHealthcare and Optum names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

EMPLOYEES

As of December 31, 2019, we employed 325,000 individuals.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following sets forth certain information regarding our executive officers as of February 14, 2020, including the business experience of each executive officer during the past five years:

Name	Age	Position
David S. Wichmann	57	Chief Executive Officer
Andrew P. Witty	55	President; Chief Executive Officer of Optum
Dirk C. McMahon	60	Chief Executive Officer of UnitedHealthcare
John F. Rex	58	Executive Vice President; Chief Financial Officer
Thomas E. Roos	47	Senior Vice President; Chief Accounting Officer
Marianne D. Short	68	Executive Vice President; Chief Legal Officer
D. Ellen Wilson	62	Executive Vice President

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Wichmann is Chief Executive Officer of UnitedHealth Group and a member of the Board of Directors and has served in that capacity since September 2017. Mr. Wichmann previously served as President of UnitedHealth Group from November 2014 to August 2017. Mr. Wichmann also served as Chief Financial Officer of UnitedHealth Group from January 2011 to June 2016. From April 2008 to November 2014, Mr. Wichmann served as Executive Vice President of UnitedHealth Group and President of UnitedHealth Group Operations.

Sir Andrew Witty is President of UnitedHealth Group and Chief Executive Officer of Optum. Sir Andrew has served as President since November 2019 and has served as Chief Executive Officer of Optum since July 2018. Witty previously served as a UnitedHealth Group director from August 2017 to March 2018. Prior to joining UnitedHealth Group, he was Chief Executive Officer and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. McMahon is Chief Executive Officer of UnitedHealthcare and has served in that capacity since June 2019. Mr. McMahon previously served as President and Chief Operating Officer of Optum from April 2017 to June 2019 and as Executive Vice President, Operations at UnitedHealth Group from November 2014 to April 2017. Mr. McMahon also served as Chief Executive Officer of OptumRx from November 2011 to November 2014. Prior to 2011, he held various positions in UnitedHealthcare in operations, technology and finance.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in that capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex was a Managing Director at JP Morgan, a global financial services firm.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in that capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Short is Executive Vice President and Chief Legal Officer of UnitedHealth Group and has served in that capacity since January 2013. Prior to joining UnitedHealth Group, Ms. Short served as the Managing Partner at Dorsey & Whitney LLP, an international law firm, from January 2007 to December 2012.

Ms. Wilson is Executive Vice President of UnitedHealth Group and has served in that capacity since June 2013. She also served as Chief Human Resources Officer of UnitedHealth Group from June 2013 through October 2019. From January 2012 to May 2013, Ms. Wilson served as Chief Administrative Officer of Optum. Prior to joining Optum, Ms. Wilson served for 17 years at Fidelity Investments, concluding her tenure there as head of Human Resources.

Additional Information

UnitedHealth Group Incorporated was incorporated in January 1977 in Minnesota. On July 1, 2015, UnitedHealth Group Incorporated changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at *www.unitedhealthgroup.com* to learn more about our company. From the site you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation, bylaws and corporate governance policies, including our Principles of Governance, Board of Directors Committee Charters and Code of Conduct. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law; we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business that investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking

statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products depends in large part on our ability to predict, price for and effectively manage medical costs. Our OptumHealth business negotiates capitation arrangements with commercial third-party payers, which are also included in premium revenues. Under the typical capitation arrangement, the health care provider receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to the capitated member. Premium revenues from risk-based products comprise nearly 80% of our total consolidated revenues. If we fail to predict accurately, or effectively price for or manage the costs of providing care to our capitated members, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of favorable provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts are typically based on a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2019 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2019 would have been reduced by approximately $320 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related

regulations and licensure requirements. 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. Any such assessment could expose our insurance entities and other insurers to the risk that they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our UnitedHealthcare and Optum businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts that we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations that are distinct from those faced by our insurance and HMO subsidiaries, including, for example, state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements, some of which could impact our relationships with physicians, hospitals and customers. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified or repealed or replaced. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part; and a federal appeals court struck down the ACA as in part unconstitutional in 2019. That case has been remanded to federal district court. Further, the integration into our businesses of entities that we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules that did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) that vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based

outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while the Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and enforcement of industry regulations that could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins, which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations that could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes that may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members that were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income

members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, implementation of material program or policy changes after our bid submission, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system that provides various quality bonus payments to Medicare Advantage plans that meet certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits that our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models that apply to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly 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 for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which have in the past resulted and could in the future result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Such investigations, audits, reviews or assessments sometimes arise out of, or prompt claims by private litigants or whistleblowers that, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which could result in adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our business is highly dependent on the integrity and timeliness of the data we use to serve our members, customers and health care professionals and to operate our business. The volume of health care data generated, and the uses of data, including electronic health records, are rapidly expanding. Our ability to implement new and innovative services, price adequately our products and services, provide effective service to our customers in an efficient and uninterrupted fashion, and report accurately our results of operations depends on the integrity of the data in our information systems. In addition, connectivity among technologies is becoming increasingly important and recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the data we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could experience failures in our health, wellness and information technology products; lose existing customers; have difficulty attracting new customers; experience problems in determining medical cost estimates and establishing appropriate pricing; have difficulty preventing, detecting and controlling fraud; have disputes with customers, physicians and other health care professionals; become subject to regulatory sanctions or penalties; incur increases in operating expenses or suffer other adverse consequences.

We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products that may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to health data and the health information technology market may alter the competitive landscape or present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we sustain cyber-attacks or other privacy or data security incidents that result in security breaches that disrupt our operations or result in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place that are intended to detect, contain and respond to data security incidents and that provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security

breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third-parties, create system disruptions or cause system shutdowns that could negatively affect our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; misplaced or lost data; human error; malicious social engineering; or other events that could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third-parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in litigation and potential liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers that utilize protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect that there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, goes into effect in 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their

actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS administers its audit program to assess HIPAA compliance efforts by covered entities and business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data that is statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties that may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. Additionally, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and entry into corporate integrity agreements. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards that impact the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the Food and Drug Administration (FDA) and Boards of Pharmacy.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans that are subject to ERISA. A private party or the DOL, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine that fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular markets, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors that give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity that has occurred in the industries in which we operate, both among our competitors and suppliers (including hospitals, physician groups and other health care professionals). Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services that are useful and relevant to consumers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage, and we may face challenges from new technologies and market entrants that could affect our existing relationship with health plan enrollees in these areas. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes that may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate

favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have capitation arrangements with some physicians, hospitals and other health care providers. Capitation arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent that a capitated health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the capitation arrangement, we may be held responsible for unpaid health care claims that should have been the responsibility of the capitated health care provider and for which we have already paid the provider. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers that render services to our members do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation that is due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard that does not clearly specify dollar terms. In some instances, providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians that practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. We face and will likely continue to face heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False

Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We may also be party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible that the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity, which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated, which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on efficiently integrating the acquired business into our existing operations, including our internal control environment, or otherwise leveraging its operations, which may present challenges that are different from those presented by organic growth and that may be difficult for us to manage. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges that differ from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management attention and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and, outside of the United States, may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions that could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies that we hold into U.S. dollars or other currencies. If we are unable to manage

successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

A number of investigations have been conducted regarding the marketing practices of producers selling health care products and the payments they receive and have resulted in enforcement actions against companies in our industry and producers marketing and selling those companies' products. If we were subjected to similar investigations and enforcement actions, such actions could result in penalties and the imposition of corrective action plans, which could materially and adversely impact our ability to market our products.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment can cause lower enrollment or lower rates of renewal in our employer group plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retrospectively to apply to payments already negotiated or received from the government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers, which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others, which could, in turn, materially and adversely affect Optum's financial results.

Our investment portfolio may suffer losses, which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities, which constitute the vast majority of the fair value of our investments as of December 31, 2019. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments, which could adversely affect our profitability and equity.

There can be no assurance that our investments will produce total positive returns or that we will not sell investments at prices that are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2019, our goodwill and other intangible assets had a carrying value of $76 billion, representing 44% of our total consolidated assets. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses that we acquire perform in a manner that is inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely affect our credit ratings and potentially impact our compliance with the financial covenants in our bank credit facilities.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our

regulated subsidiaries that exceed specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance that our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions "Legal Matters" and "Governmental Investigations, Audits and Reviews" in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED SHAREHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 31, 2020, there were 11,517 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2019, the Company's Board of Directors increased the Company's quarterly cash divided to shareholders to an annual rate of $4.32 compared to $3.60 per share, which the Company had paid since June 2018. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

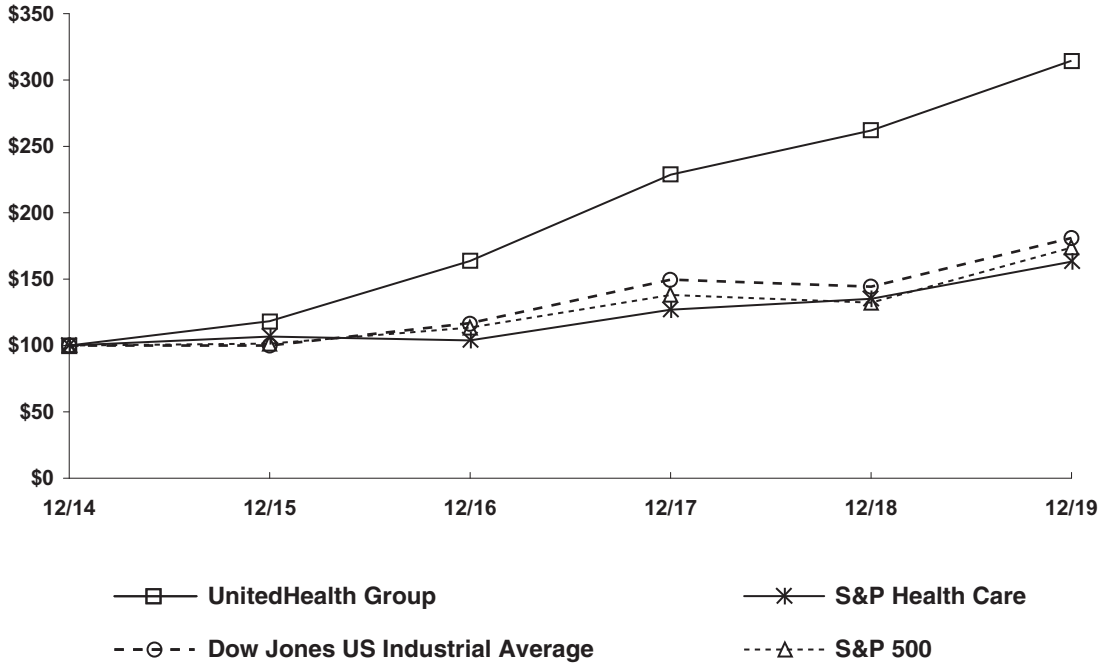
In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2019, we repurchased 1.6 million shares at an average price of $256.55 per share. As of December 31, 2019, we had Board authorization to purchase up to 72 million shares of our common stock.

PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 index, the S&P Health Care Index and the Dow Jones US Industrial Average Index for the five-year period ended December 31, 2019. The comparisons assume the investment of $100 on December 31, 2014 in our common stock and in each index, and that dividends were reinvested when paid.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 Index



	12/14	12/15	12/16	12/17	12/18	12/19
UnitedHealth Group	**$100.00**	**$118.26**	**$163.68**	**$228.86**	**$262.09**	**$314.47**
S&P Health Care Index	**100.00**	**106.89**	**104.01**	**126.98**	**135.19**	**163.34**
Dow Jones US Industrial Average	**100.00**	**100.21**	**116.74**	**149.56**	**144.35**	**180.94**
S&P 500 Index	**100.00**	**101.38**	**113.51**	**138.29**	**132.23**	**173.86**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

(in millions, except percentages and per share data)	For the Years Ended December 31, 2019	2018	2017 (a)	2016	2015 (b)
Consolidated operating results					
Revenues	$242,155	$226,247	$201,159	$184,840	$157,107
Earnings from operations	19,685	17,344	15,209	12,930	11,021
Net earnings attributable to UnitedHealth Group common shareholders	13,839	11,986	10,558	7,017	5,813
Return on equity (c)	25.7%	24.4%	24.4%	19.4%	17.7%
Basic earnings per share attributable to UnitedHealth Group common shareholders	$ 14.55	$ 12.45	$ 10.95	$ 7.37	$ 6.10
Diluted earnings per share attributable to UnitedHealth Group common shareholders	14.33	12.19	10.72	7.25	6.01
Cash dividends declared per common share	4.14	3.45	2.875	2.375	1.875
Consolidated cash flows from (used for)					
Operating activities	$ 18,463	$ 15,713	$ 13,596	$ 9,795	$ 9,740
Investing activities	(12,699)	(12,385)	(8,599)	(9,355)	(18,395)
Financing activities	(5,625)	(4,365)	(3,441)	(1,011)	12,239
Consolidated financial condition					
(as of December 31)					
Cash and investments	$ 51,454	$ 46,834	$ 43,831	$ 37,143	$ 31,703
Total assets	173,889	152,221	139,058	122,810	111,254
Total commercial paper and long-term debt	40,678	36,554	31,692	32,970	31,965
Redeemable noncontrolling interests	1,726	1,908	2,189	2,012	1,736
Total equity	60,436	54,319	49,833	38,177	33,725

(a) Includes the impact of the revaluation of our net deferred tax liabilities due to tax reform enacted in December 2017.

(b) Includes the effects of the July 2015 acquisition of Catamaran Corporation (Catamaran) and related debt issuances.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

This selected financial data should be read with the accompanying "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 and the Consolidated Financial Statements and Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Item 8, "Financial Statements and Supplementary Data." Readers are cautioned that the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

Discussions of year-over-year comparisons between 2018 and 2017 that are not included in this Form 10-K can be found in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" of the Company's Form 10-K for the fiscal year ended December 31, 2018.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone. Through our diversified businesses, we leverage core competencies in data analytics and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

We have four reportable segments across our two business platforms, UnitedHealthcare and Optum:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, which could impact our results of operations, including our continued efforts to control health care costs.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs. The ACA, which includes three distinct taxes (ACA Tax), has an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A provision in the 2018 federal budget imposed a one year moratorium for 2019 on the collection of the Health Insurance Industry Tax. Pricing for contracts that cover some portion of calendar year 2020 reflect the return of the Health Insurance Industry Tax. The ACA Tax was permanently repealed by Congress, effective January 1, 2021.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe that the payment rate environment creates the risk of continued downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates that are commensurate with our medical cost trends and we remain dedicated to partnering with those states that are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying incentive-based care provider payment models that reward high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2019, we served over 17 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches. As of December 31, 2019, our contracts with value-based elements totaled $79 billion in annual spending, including $20 billion through risk-transfer agreements.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2020 Medicare Advantage rates resulted in an increase in industry base rates of approximately 2.5%, short of the industry forward medical cost trend. This combined with the return of the Health Insurance Industry Tax creates continued pressure in the Medicare Advantage program.

The ongoing Medicare Advantage funding pressure places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums that supplement the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

ACA Tax. A provision in the 2019 Federal Budget imposed a one year moratorium for 2019 on the collection of the Health Insurance Industry Tax. In 2020, the industry-wide amount of the Health Insurance Industry Tax, which is primarily borne by customers, will be $15.5 billion and we expect our portion to be approximately $3.0 billion. The ACA Tax was repealed by Congress, effective January 1, 2021.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2019 year-over-year operating comparisons to 2018.

- Consolidated revenues increased by 7%, UnitedHealthcare revenues increased 6% and Optum revenues grew 12%.
- UnitedHealthcare served 575,000 additional people domestically as a result of growth in commercial business and services to seniors, partially offset by the proactive withdrawal from the Iowa medicaid market.
- Earnings from operations increased by 13%, including increases of 13% at UnitedHealthcare and 14% at Optum.
- Diluted earnings per common share increased 18% to $14.33.
- Cash flows from operations were $18.5 billion, an increase of 18%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2019	2018	2017	Change 2019 vs. 2018	
Revenues:					
Premiums	$189,699	$178,087	$158,453	$11,612	7%
Products	31,597	29,601	26,366	1,996	7
Services	18,973	17,183	15,317	1,790	10
Investment and other income	1,886	1,376	1,023	510	37
Total revenues	242,155	226,247	201,159	15,908	7
Operating costs:					
Medical costs	156,440	145,403	130,036	11,037	8
Operating costs	35,193	34,074	29,557	1,119	3
Cost of products sold	28,117	26,998	24,112	1,119	4
Depreciation and amortization	2,720	2,428	2,245	292	12
Total operating costs	222,470	208,903	185,950	13,567	6
Earnings from operations	19,685	17,344	15,209	2,341	13
Interest expense	(1,704)	(1,400)	(1,186)	(304)	22
Earnings before income taxes	17,981	15,944	14,023	2,037	13
Provision for income taxes	(3,742)	(3,562)	(3,200)	(180)	5
Net earnings	14,239	12,382	10,823	1,857	15
Earnings attributable to noncontrolling interests	(400)	(396)	(265)	(4)	1
Net earnings attributable to UnitedHealth Group common shareholders	$ 13,839	$ 11,986	$ 10,558	$ 1,853	15%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 14.33	$ 12.19	$ 10.72	$ 2.14	18%
Medical care ratio (a)	82.5%	81.6%	82.1%	0.9%	
Operating cost ratio	14.5	15.1	14.7	(0.6)	
Operating margin	8.1	7.7	7.6	0.4	
Tax rate	20.8	22.3	22.8	(1.5)	
Net earnings margin (b)	5.7	5.3	5.2	0.4	
Return on equity (c)	25.7%	24.4%	24.4%	1.3%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2019 RESULTS OF OPERATIONS COMPARED TO 2018 RESULTS

Consolidated Financial Results

Revenue

The increase in revenue was primarily driven by the increase in the number of individuals served through Medicare Advantage; pricing trends; and organic and acquisition growth across the Optum business, primarily due to expansion in pharmacy care services and care delivery, partially offset by the moratorium of the Health Insurance Industry Tax in 2019.

Medical Costs and MCR

Medical costs increased due to growth in people served through Medicare Advantage and medical cost trends, partially offset by increased prior year favorable medical development. The MCR increased due to the revenue effects of the Health Insurance Industry Tax moratorium.

Reportable Segments

See Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more information on our segments. The following table presents a summary of the reportable segment financial information:

	For the Years Ended December 31,			Change	
(in millions, except percentages)	2019	2018	2017	2019 vs. 2018	
Revenues					
UnitedHealthcare	$193,842	$183,476	$163,257	$10,366	6%
OptumHealth	30,317	24,145	20,570	6,172	26
OptumInsight	10,006	9,008	8,087	998	11
OptumRx	74,288	69,536	63,755	4,752	7
Optum eliminations	(1,661)	(1,409)	(1,227)	(252)	18
Optum	112,950	101,280	91,185	11,670	12
Eliminations	(64,637)	(58,509)	(53,283)	(6,128)	10
Consolidated revenues	$242,155	$226,247	$201,159	$15,908	7%
Earnings from operations					
UnitedHealthcare	$ 10,326	$ 9,113	$ 8,498	$ 1,213	13%
OptumHealth	2,963	2,430	1,823	533	22
OptumInsight	2,494	2,243	1,770	251	11
OptumRx	3,902	3,558	3,118	344	10
Optum	9,359	8,231	6,711	1,128	14
Consolidated earnings from operations	$ 19,685	$ 17,344	$ 15,209	$ 2,341	13%
Operating margin					
UnitedHealthcare	5.3%	5.0%	5.2%	0.3%	
OptumHealth	9.8	10.1	8.9	(0.3)	
OptumInsight	24.9	24.9	21.9	—	
OptumRx	5.3	5.1	4.9	0.2	
Optum	8.3	8.1	7.4	0.2	
Consolidated operating margin	8.1%	7.7%	7.6%	0.4%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

	For the Years Ended December 31,			Change	
(in millions, except percentages)	2019	2018	2017	2019 vs. 2018	
UnitedHealthcare Employer & Individual	$ 56,945	$ 54,761	$ 52,066	$ 2,184	4%
UnitedHealthcare Medicare & Retirement	83,252	75,473	65,995	7,779	10
UnitedHealthcare Community & State	43,790	43,426	37,443	364	1
UnitedHealthcare Global	9,855	9,816	7,753	39	—
Total UnitedHealthcare revenues	$193,842	$183,476	$163,257	$10,366	6%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2019	2018	2017	Change 2019 vs. 2018	
Commercial:					
Risk-based	8,575	8,495	8,420	80	1%
Fee-based	19,185	18,420	18,595	765	4
Fee-based TRICARE	—	—	2,850	—	—
Total commercial	27,760	26,915	29,865	845	3
Medicare Advantage	5,270	4,945	4,430	325	7
Medicaid	5,900	6,450	6,705	(550)	(9)
Medicare Supplement (Standardized)	4,500	4,545	4,445	(45)	(1)
Total public and senior	15,670	15,940	15,580	(270)	(2)
Total UnitedHealthcare — domestic medical	43,430	42,855	45,445	575	1
International	5,720	6,220	4,080	(500)	(8)
Total UnitedHealthcare — medical	49,150	49,075	49,525	75	—%
Supplemental Data:					
Medicare Part D stand-alone	4,405	4,710	4,940	(305)	(6)%

Fee-based commercial group business increased primarily due to an acquisition. Medicare Advantage increased due to the growth in people served through individual and employer-sponsored group Medicare Advantage plans. The decrease in people served through Medicaid was primarily driven by the proactive withdrawal from the Iowa market as well as by states adding new carriers to existing programs and managing eligibility, partially offset by increases in Dual Special Needs Plans. The decrease in people served internationally is a result of our continued affordability efforts and underwriting discipline.

UnitedHealthcare's revenue and earnings from operations increased due to growth in the number of individuals served through Commercial and Medicare Advantage, including a greater mix of people with a higher acuity needs. Revenue increases were partially offset by the moratorium on the Health Insurance Industry Tax in 2019. Earnings from operations were also favorably impacted by operating cost management.

Optum

Total revenues and earnings from operations increased as each segment reported increased revenues and earnings from operations as a result of the factors discussed below. Earnings from operations also increased due to productivity and overall cost management initiatives.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth primarily due to organic growth and acquisitions in care delivery, increased care services and organic growth in behavioral health services. Earnings from operations increased primarily due to care delivery. OptumHealth served approximately 96 million and 93 million people as of December 31, 2019 and 2018, respectively.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to organic and acquisition growth in managed services.

OptumRx

Revenue at OptumRx increased primarily due to organic growth and acquisitions in specialty pharmacy, partially offset by an expected large client transition. Earnings from operations increased primarily due to the factors that increased revenue as well as improved supply chain management. OptumRx fulfilled 1,340 million and 1,343 million adjusted scripts in 2019 and 2018, respectively, with 2019 impacted by the large client transition.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to, among other things, minimal levels of statutory capital, as defined by their respective jurisdiction, and restrictions on the timing and amount of dividends paid to their parent companies.

Our U.S. regulated subsidiaries paid their parent companies dividends of $5.6 billion and $3.7 billion in 2019 and 2018, respectively. See Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through dividends and repurchases of our common stock.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2019	2018	2017	Change 2019 vs. 2018
Sources of cash:				
Cash provided by operating activities	$ 18,463	$ 15,713	$ 13,596	$ 2,750
Issuances of long-term debt and commercial paper, net of repayments	3,994	4,134	—	(140)
Proceeds from common share issuances	1,037	838	688	199
Customer funds administered	13	—	3,172	13
Other	219	—	—	219
Total sources of cash	23,726	20,685	17,456	
Uses of cash:				
Cash paid for acquisitions, net of cash assumed	(8,343)	(5,997)	(2,131)	(2,346)
Cash dividends paid	(3,932)	(3,320)	(2,773)	(612)
Common share repurchases	(5,500)	(4,500)	(1,500)	(1,000)
Repayments of long-term debt and commercial paper, net of issuances	—	—	(2,615)	—
Purchases of property, equipment and capitalized software	(2,071)	(2,063)	(2,023)	(8)
Purchases of investments, net of sales and maturities	(2,504)	(4,099)	(4,319)	1,595
Other	(1,237)	(1,743)	(539)	506
Total uses of cash	(23,587)	(21,722)	(15,900)	
Effect of exchange rate changes on cash and cash equivalents	(20)	(78)	(5)	58
Net increase (decrease) in cash and cash equivalents	$ 119	$ (1,115)	$ 1,551	$ 1,234

2019 Cash Flows Compared to 2018 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings as well as changes in working capital accounts. Other significant changes in sources or uses of cash year-over-year included an increase in cash paid for acquisitions, increased share repurchases and decreased net purchases of investments.

Financial Condition

As of December 31, 2019, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $49.1 billion included $11.0 billion of cash and cash equivalents (of which $584 million was available for general corporate use), $36.1 billion of debt securities and $2.0 billion of investments in equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.4 years and a weighted-average credit rating of “Double A” as of December 31, 2019. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through independent broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of December 31, 2019, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 39%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements and Supplementary Data."

Credit Ratings. Our credit ratings as of December 31, 2019 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A-	Stable	A-	Positive
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. A significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2019, we had Board authorization to purchase up to 72 million shares of our common stock. For more information on our share repurchase program, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

Dividends. In June 2019, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $4.32 compared to $3.60 per share. For more information on our dividend, see Note 10 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

The following table summarizes future obligations due by period as of December 31, 2019, under our various contractual obligations and commitments:

(in millions)	2020	2021 to 2022	2023 to 2024	Thereafter	Total
Debt (a)	$ 5,532	$ 9,118	$ 6,122	$ 44,302	$ 65,074
Operating leases	804	1,327	901	1,671	4,703
Purchase and other obligations (b)	1,617	2,483	768	248	5,116
Other liabilities (c)	914	344	285	7,767	9,310
Redeemable noncontrolling interests (d)	852	542	—	332	1,726
Total contractual obligations	$ 9,719	$ 13,814	$ 8,076	$ 54,320	$ 85,929

(a) Includes interest coupon payments and maturities at par or put values. The table also assumes amounts are outstanding through their contractual term. See Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data" for more detail.

(b) Includes fixed or minimum commitments under existing purchase obligations for goods and services, including agreements that are cancelable with the payment of an early termination penalty and remaining capital commitments for venture capital funds and other funding commitments. Excludes agreements that are cancelable without penalty and excludes liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2019.

(c) Includes obligations associated with contingent consideration and payments related to business acquisitions, certain employee benefit programs, amounts accrued for guaranty fund assessments, unrecognized tax benefits, and various long-term liabilities. Due to uncertainty regarding payment timing, obligations for employee benefit programs, charitable contributions, future settlements, unrecognized tax benefits and other liabilities have been classified as "Thereafter."

(d) Includes commitments for redeemable shares of our subsidiaries. When the timing of the redemption is indeterminable, the commitment has been classified as "Thereafter."

We do not have other significant contractual obligations or commitments that require cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

OFF-BALANCE SHEET ARRANGEMENTS

As of December 31, 2019, we were not involved in any off-balance sheet arrangements, which have or are reasonably likely to have a material effect on our financial condition, results of operations or liquidity.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements and Supplementary Data" for a discussion of new accounting pronouncements that affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates that require management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters that are inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties that are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2019, our days outstanding in medical payables was 51 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2019, 2018 and 2017 included favorable medical cost development related to prior years of $580 million, $320 million and $690 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim levels and processing cycles, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2019:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 584
(0.50)	388
(0.25)	194
0.25	(193)
0.50	(384)
0.75	(575)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, including but not limited to, pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our

estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes and epidemics.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2019:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 754
2	502
1	251
(1)	(251)
(2)	(502)
(3)	(754)

The completion factors and medical costs PMPM trend factors analyses above include outcomes that are considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2019; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2019 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2019 net earnings would have increased or decreased by approximately $160 million.

For more detail related to our medical cost estimates, see Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements and Supplementary Data.”

Goodwill

We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change that indicate the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates that goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a multi-step test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows, which include assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods and discount rates. For each reporting unit, comparative market multiples are used to corroborate the results of our discounted cash flow test.

Forecasts and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Key assumptions used in these forecasts include:

- *Revenue trends.* Key revenue drivers for each reporting unit are determined and assessed. Significant factors include: customer and/or membership growth, medical trends and the impact and expectations of regulatory environments. Additional macro-economic assumptions relating to unemployment, GDP growth, interest rates and inflation are also evaluated and incorporated, as appropriate.
- *Medical cost trends.* For further discussion of medical cost trends, see the "Medical Cost Trend" section of Executive Overview-Business Trends and the "Medical Costs Payable" critical accounting estimate above. Similar factors, including historical and expected medical cost trend levels, are considered in estimating our long-term medical trends at the reporting unit level.
- *Operating productivity.* We forecast expected operating cost levels based on historical levels and expectations of future operating cost levels.
- *Capital levels.* The operating and long-term capital requirements for each business are considered.

Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital that reflect reporting unit-specific factors. We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. As of October 1, 2019, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts that may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations that are investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers that constitute our client base. As of December 31, 2019, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2019, we had $14 billion of financial assets on which the interest rates received vary with market interest rates, which may significantly impact our investment income. Also as of December 31, 2019, $9 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2019, $33 billion of our investments were fixed-rate debt securities and $39 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2019 and 2018 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2019			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets (a)	Fair Value of Financial Liabilities
2%	$ 282	$ 185	$ (2,668)	$ (6,813)
1	141	93	(1,331)	(3,704)
(1)	(141)	(93)	1,246	4,433
(2)	(282)	(185)	2,071	9,613

	December 31, 2018			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets (a)	Fair Value of Financial Liabilities
2%	$ 276	$ 189	$ (2,242)	$ (5,017)
1	138	94	(1,140)	(2,724)
(1)	(138)	(94)	1,118	3,155
(2)	(276)	(189)	2,196	6,953

(a) As of December 31, 2019 and 2018, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the exchange rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2019, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $600 million and $1.3 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2019, we had $2.0 billion of investments in equity securities, primarily consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2019 and 2018, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2019, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 14, 2020 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current-period audit of the financial statements that were communicated or required to be communicated to the audit committee and that (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Incurred but not Reported (IBNR) Claim Liability—Refer to Notes 2 and 7 to the financial statements.

Critical Audit Matter Description

Medical costs payable includes estimates of the Company's obligations for medical care services rendered on behalf of insured consumers, for which claims have either not yet been received or processed. These estimates

are referred to as incurred but not reported (IBNR) claim liabilities. The Company develops IBNR estimates using an actuarial model that requires management to exercise certain judgments in developing its estimates. Judgments made by management include the time from date of service to claim receipt, the impact of claim levels and processing cycles, as well as other factors.

We identified the IBNR claim liability as a critical audit matter because of the significant assumptions made by management in estimating the liability. This required complex auditor judgment, and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management's methods, assumptions and judgments in developing the liability.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures included the following, among others:

- We tested the effectiveness of controls over management's estimate of the IBNR claim liability balance, including controls over the judgments of time from date of service to claim receipt, and the impact of claim levels and processing cycles.
- We tested the underlying claims and membership data and other information that served as the basis for the actuarial analysis, to test that the inputs to the actuarial estimate were complete and accurate.
- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate the IBNR claim liability by:
    - Performing an overlay of the historical claims data used in management's current year model to the data used in prior periods to validate that there were no material changes to the claims data tested in prior periods.
    - Developing an independent estimate of the IBNR claim liability and comparing our estimate to management's estimate.
    - Performing a retrospective review comparing management's prior year assumptions of the estimate of IBNR to claims processed in 2019 with dates of service in 2018 or prior.

Goodwill—Refer to Notes 2 and 6 to the financial statements.

Critical Audit Matter Description

At December 31, 2019, the Company's goodwill balance was $66 billion. As discussed in Note 2 of the financial statements, goodwill is tested for impairment for certain of the Company's reporting units, at least annually, by comparing the carrying values of the reporting units to the estimated fair values as of the impairment testing date. The estimates of the reporting unit fair values are calculated using discounted cash flows, which include financial projections including significant assumptions about revenue trends, medical cost trends, and operating costs as well as discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. The fair values of the reporting units exceeded the carrying values as of the impairment testing date, therefore no impairment was recognized.

We identified certain reporting units as a critical audit matter because of the significant assumptions made by management to estimate the fair value of the reporting unit. This required increased auditor judgment and extent of effort, including involvement of fair value specialists to evaluate the reasonableness of management's estimates and assumptions related to financial projections, which can be impacted by regulatory and macro-economic factors.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to the valuation and business assumptions including the discount rate and financial forecasts used by management to estimate the fair value of certain reporting units included the following, among others:

- We tested the effectiveness of controls over management's annual goodwill impairment assessment, including those over the determination of the fair value such as controls related to management's financial forecasts, as well as controls over the selection of discount rates and company specific risks.
- We evaluated management's ability to forecast and meet future revenue, medical cost trend, and operating costs by comparing:
  - Actual results to historical forecasts.
  - Forecasted information to: internal communications to management and the Board of Directors, industry and economic trends, and analyst reports of revenue and earnings expectations for the Company and its peers.
- We evaluated the impact of changes in management's forecasts from the October 1, 2019 annual measurement date to December 31, 2019.
- With the assistance of our fair value specialists, we evaluated the reasonableness of the (1) valuation methodology, including testing the mathematical accuracy of the calculation and (2) discount rate and company specific risks by:
  - Testing the source information underlying the determination of the discount rate and the mathematical accuracy of the calculation.
  - Developing a range of independent discount rate estimates and comparing to those selected by management.

/S/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 14, 2020

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 10,985	$ 10,866
Short-term investments	3,260	3,458
Accounts receivable, net of allowances of $519 and $712	11,822	11,388
Other current receivables, net of allowances of $859 and $502	9,640	6,862
Assets under management	3,076	3,032
Prepaid expenses and other current assets	3,851	3,086
Total current assets	42,634	38,692
Long-term investments	37,209	32,510
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $4,995 and $4,141	8,704	8,458
Goodwill	65,659	58,910
Other intangible assets, net of accumulated amortization of $5,072 and $4,592	10,349	9,325
Other assets	9,334	4,326
Total assets	$ 173,889	$ 152,221
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 21,690	$ 19,891
Accounts payable and accrued liabilities	19,005	16,705
Commercial paper and current maturities of long-term debt	3,870	1,973
Unearned revenues	2,622	2,396
Other current liabilities	14,595	12,244
Total current liabilities	61,782	53,209
Long-term debt, less current maturities	36,808	34,581
Deferred income taxes	2,993	2,474
Other liabilities	10,144	5,730
Total liabilities	111,727	95,994
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	1,726	1,908
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 948 and 960 issued and outstanding	9	10
Additional paid-in capital	7	—
Retained earnings	61,178	55,846
Accumulated other comprehensive loss	(3,578)	(4,160)
Nonredeemable noncontrolling interests	2,820	2,623
Total equity	60,436	54,319
Total liabilities, redeemable noncontrolling interests and equity	$ 173,889	$ 152,221

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2019	2018	2017
Revenues:			
Premiums	$189,699	$178,087	$158,453
Products	31,597	29,601	26,366
Services	18,973	17,183	15,317
Investment and other income	1,886	1,376	1,023
Total revenues	242,155	226,247	201,159
Operating costs:			
Medical costs	156,440	145,403	130,036
Operating costs	35,193	34,074	29,557
Cost of products sold	28,117	26,998	24,112
Depreciation and amortization	2,720	2,428	2,245
Total operating costs	222,470	208,903	185,950
Earnings from operations	19,685	17,344	15,209
Interest expense	(1,704)	(1,400)	(1,186)
Earnings before income taxes	17,981	15,944	14,023
Provision for income taxes	(3,742)	(3,562)	(3,200)
Net earnings	14,239	12,382	10,823
Earnings attributable to noncontrolling interests	(400)	(396)	(265)
Net earnings attributable to UnitedHealth Group common shareholders	$ 13,839	$ 11,986	$ 10,558
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 14.55	$ 12.45	$ 10.95
Diluted	$ 14.33	$ 12.19	$ 10.72
Basic weighted-average number of common shares outstanding	951	963	964
Dilutive effect of common share equivalents	15	20	21
Diluted weighted-average number of common shares outstanding	966	983	985
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	10	6	5

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2019	2018	2017
Net earnings	$14,239	$12,382	$10,823
Other comprehensive income (loss):			
Gross unrealized gains (losses) on investment securities during the period	1,212	(294)	209
Income tax effect	(279)	67	(72)
Total unrealized gains (losses), net of tax	933	(227)	137
Gross reclassification adjustment for net realized gains included in net earnings	(104)	(62)	(83)
Income tax effect	24	14	30
Total reclassification adjustment, net of tax	(80)	(48)	(53)
Total foreign currency translation losses	(271)	(1,242)	(70)
Other comprehensive income (loss)	582	(1,517)	14
Comprehensive income	14,821	10,865	10,837
Comprehensive income attributable to noncontrolling interests	(400)	(396)	(265)
Comprehensive income attributable to UnitedHealth Group common shareholders	$14,421	$10,469	$10,572

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income: Net Unrealized (Losses) Gains on Investments	Accumulated Other Comprehensive (Loss) Income: Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2017	952	$ 10	$ —	$ 40,945	$ (97)	$ (2,584)	$ (97)	$38,177
Net earnings				10,558			194	10,752
Other comprehensive income (loss)					84	(70)		14
Issuances of common stock, and related tax effects	26	—	2,225					2,225
Share-based compensation			582					582
Common share repurchases	(9)	—	(1,500)					(1,500)
Cash dividends paid on common shares ($2.875 per share)				(2,773)				(2,773)
Acquisition of redeemable noncontrolling interest shares			283					283
Redeemable noncontrolling interest fair value and other adjustments			113					113
Acquisition and other adjustments of nonredeemable noncontrolling interests							2,112	2,112
Distributions to nonredeemable noncontrolling interest							(152)	(152)
Balance at December 31, 2017	969	10	1,703	48,730	(13)	(2,654)	2,057	49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				11,986			273	12,259
Other comprehensive loss					(275)	(1,242)		(1,517)
Issuances of common stock, and related tax effects	10	—	814					814
Share-based compensation			620					620
Common share repurchases	(19)	—	(2,974)	(1,526)				(4,500)
Cash dividends paid on common shares ($3.45 per share)				(3,320)				(3,320)
Redeemable noncontrolling interest fair value and other adjustments			(163)					(163)
Acquisition and other adjustments of nonredeemable noncontrolling interests							521	521
Distributions to nonredeemable noncontrolling interest							(228)	(228)
Balance at December 31, 2018	960	10	—	55,846	(264)	(3,896)	2,623	54,319
Adjustment to adopt ASU 2016-02				(13)			(5)	(18)
Net earnings				13,839			285	14,124
Other comprehensive income (loss)					853	(271)		582
Issuances of common stock, and related tax effects	10	—	696					696
Share-based compensation			673					673
Common share repurchases	(22)	(1)	(937)	(4,562)				(5,500)
Cash dividends paid on common shares ($4.14 per share)				(3,932)				(3,932)
Redeemable noncontrolling interests fair value and other adjustments			(316)					(316)
Acquisition and other adjustments of nonredeemable noncontrolling interests			(109)				196	87
Distributions to nonredeemable noncontrolling interests							(279)	(279)
Balance at December 31, 2019	948	$ 9	$ 7	$ 61,178	$ 589	$ (4,167)	$ 2,820	$60,436

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2019	2018	2017
Operating activities			
Net earnings	$ 14,239	$ 12,382	$ 10,823
Noncash items:			
Depreciation and amortization	2,720	2,428	2,245
Deferred income taxes	230	42	(965)
Share-based compensation	697	638	597
Other, net	(106)	(71)	217
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	162	(1,351)	(1,062)
Other assets	(1,563)	(750)	(630)
Medical costs payable	1,221	1,831	1,284
Accounts payable and other liabilities	733	526	930
Unearned revenues	130	38	157
Cash flows from operating activities	18,463	15,713	13,596
Investing activities			
Purchases of investments	(18,131)	(14,010)	(14,588)
Sales of investments	8,536	3,641	4,623
Maturities of investments	7,091	6,270	5,646
Cash paid for acquisitions, net of cash assumed	(8,343)	(5,997)	(2,131)
Purchases of property, equipment and capitalized software	(2,071)	(2,063)	(2,023)
Other, net	219	(226)	(126)
Cash flows used for investing activities	(12,699)	(12,385)	(8,599)
Financing activities			
Common share repurchases	(5,500)	(4,500)	(1,500)
Cash dividends paid	(3,932)	(3,320)	(2,773)
Proceeds from common stock issuances	1,037	838	688
Repayments of long-term debt	(1,750)	(2,600)	(4,398)
Proceeds from (repayments of) commercial paper, net	300	(201)	(3,508)
Proceeds from issuance of long-term debt	5,444	6,935	5,291
Customer funds administered	13	(131)	3,172
Other, net	(1,237)	(1,386)	(413)
Cash flows used for financing activities	(5,625)	(4,365)	(3,441)
Effect of exchange rate changes on cash and cash equivalents	(20)	(78)	(5)
Increase (decrease) in cash and cash equivalents	119	(1,115)	1,551
Cash and cash equivalents, beginning of period	10,866	11,981	10,430
Cash and cash equivalents, end of period	$ 10,985	$ 10,866	$ 11,981
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,627	$ 1,410	$ 1,133
Cash paid for income taxes	3,542	3,257	4,004
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ —	$ 2,164

See Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health care company dedicated to helping people live healthier lives and helping make the health system work better for everyone.

Through its diversified family of businesses, the Company leverages core competencies in data and health information; advanced technology; and clinical expertise. These core competencies are deployed within two distinct, but strategically aligned, business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets and estimates of other current liabilities and other current receivables. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, that fall below certain targets are required to rebate ratable portions of their premiums annually. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star ratings.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues from capitation arrangements at its OptumHealth businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model that apportions

premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis and encounter data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and community health pharmacies. Product revenues include ingredient costs (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's home delivery, specialty and community pharmacies. In retail pharmacy transactions, revenues recognized exclude the member's applicable co-payment. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers that self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. 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 premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues that are recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and managed services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2019 and 2018, accounts receivables related to products and services were $4.3 billion and $3.9 billion, respectively. In 2019 and 2018, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2019 or 2018.

For the years ended December 31, 2019 and 2018, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts that have an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 14 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2019.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims that have not been received or fully processed, using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery and specialty pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments that have an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized 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 security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of 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, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement with AARP, program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to that entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, accrued interest and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2019 and 2018, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $4.7 billion and $4.2 billion, respectively.

As of December 31, 2019 and 2018, the Company's Medicare Part D receivables amounted to $2.3 billion and $0.8 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Operating Leases

The Company leases facilities and equipment under long-term operating leases that are non-cancelable and expire on various dates. At the lease commencement date, lease right-of-use (ROU) assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period that closely matches the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Consolidated Balance Sheet.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs a multi-step impairment test. The Company may first assess qualitative factors to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value and discount rates. Comparative market multiples are used to corroborate the results of the discounted cash flow test. If the fair value is less than the carrying value of the reporting unit, then the implied

value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

There was no impairment of goodwill during the year ended December 31, 2019.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate that an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2019.

Other Current Liabilities

Other current liabilities include health savings account deposits ($8.3 billion and $7.5 billion as of December 31, 2019 and 2018, respectively), deposits under the Medicare Part D program ($0.5 billion as of December 31, 2019 and 2018), the RSF associated with the AARP Program, accruals for premium rebate payments under the ACA, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2019 and 2018:

(in millions)	2019	2018
Redeemable noncontrolling interests, beginning of period	$1,908	$2,189
Net earnings	115	123
Acquisitions	90	102
Redemptions	(618)	(90)
Distributions	(69)	(53)
Fair value and other adjustments	300	(363)
Redeemable noncontrolling interests, end of period	$1,726	$1,908

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over two to four years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 85% of the lower market

price of the Company's common stock at the beginning or at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Health Insurance Industry Tax

The ACA includes an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. A one year moratorium on the collection of the Health Insurance Industry Tax occurred in 2019. The Health Insurance Industry Tax will be levied in 2020, however, it was permanently repealed by Congress for subsequent years.

The Company estimates its liability for the Health Insurance Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Health Insurance Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Consolidated Statements of Operations using a straight-line method over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Consolidated Balance Sheets.

Recently Issued Accounting Standards

In June 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-13, "Financial Instruments—Credit Losses (Topic 326)" (ASU 2016-13). ASU 2016-13 requires the use of the current expected credit loss impairment model to develop an estimate of expected credit losses for certain financial assets. ASU 2016-13 also requires expected credit losses on available-for-sale debt securities to be recognized through an allowance for credit losses and revises certain disclosure requirements. The Company adopted ASU 2016-13 using a cumulative effect upon adoption approach on January 1, 2020. The adoption resulted in no material impact to the Company's balance sheet, results of operations, equity or cash flows.

Recently Adopted Accounting Standards

In February 2016, the FASB issued ASU No. 2016-02, "Leases (Topic 842)" as modified by ASUs 2018-01, 2018-10, 2018-11, 2018-20 and 2019-01 (collectively, ASU 2016-02). Under ASU 2016-02, an entity is required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. The Company adopted ASU 2016-02 using a cumulative-effect upon adoption approach as of January 1, 2019. Upon adoption, the Company recognized $3.3 billion of ROU assets and lease liabilities for operating leases on its Consolidated Balance Sheet, of which, $668 million were classified as current liabilities. The adoption of ASU 2016-02 was immaterial to the Company's consolidated results of operations, equity and cash flows. The Company has included the disclosures required by ASU 2016-02 above and in Note 12.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2019				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,502	$ 55	$ (4)	$ 3,553
State and municipal obligations	5,680	251	(5)	5,926
Corporate obligations	17,910	343	(11)	18,242
U.S. agency mortgage-backed securities	6,425	109	(6)	6,528
Non-U.S. agency mortgage-backed securities	1,811	37	(3)	1,845
Total debt securities — available-for-sale	35,328	795	(29)	36,094
Debt securities — held-to-maturity:				
U.S. government and agency obligations	402	2	—	404
State and municipal obligations	32	2	—	34
Corporate obligations	538	—	(1)	537
Total debt securities — held-to-maturity	972	4	(1)	975
Total debt securities	$ 36,300	$ 799	$ (30)	$ 37,069
December 31, 2018				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,434	$ 13	$ (42)	$ 3,405
State and municipal obligations	7,117	61	(57)	7,121
Corporate obligations	15,366	14	(218)	15,162
U.S. agency mortgage-backed securities	4,947	11	(106)	4,852
Non-U.S. agency mortgage-backed securities	1,376	2	(20)	1,358
Total debt securities — available-for-sale	32,240	101	(443)	31,898
Debt securities — held-to-maturity:				
U.S. government and agency obligations	255	1	(2)	254
State and municipal obligations	11	—	—	11
Corporate obligations	355	—	—	355
Total debt securities — held-to-maturity	621	1	(2)	620
Total debt securities	$ 32,861	$ 102	$ (445)	$ 32,518

Nearly all of the Company's investments in mortgage-backed securities were rated AAA as of December 31, 2019.

The Company held $2.0 billion of equity securities as of December 31, 2019 and December 31, 2018. The Company's investments in equity securities primarily consist of employee savings plan related investments, shares of Brazilian real denominated fixed-income funds and dividend paying stocks with readily determinable fair values. Additionally, the Company's investments included $1.4 billion and $1.5 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2019 and 2018, respectively.

The amortized cost and fair value of debt securities as of December 31, 2019, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 3,382	$ 3,388	$ 314	$ 314
Due after one year through five years	11,966	12,159	391	392
Due after five years through ten years	8,307	8,643	144	144
Due after ten years	3,437	3,531	123	125
U.S. agency mortgage-backed securities	6,425	6,528	—	—
Non-U.S. agency mortgage-backed securities	1,811	1,845	—	—
Total debt securities	$ 35,328	$36,094	$ 972	$ 975

The fair value of available-for-sale debt securities with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2019						
U.S. government and agency obligations	$ 616	$ (4)	$ —	$ —	$ 616	$ (4)
State and municipal obligations	440	(5)	—	—	440	(5)
Corporate obligations	1,903	(7)	740	(4)	2,643	(11)
U.S. agency mortgage-backed securities	657	(3)	333	(3)	990	(6)
Non-U.S. agency mortgage-backed securities	406	(3)	—	—	406	(3)
Total debt securities — available-for-sale	$ 4,022	$ (22)	$ 1,073	$ (7)	$ 5,095	$ (29)
December 31, 2018						
U.S. government and agency obligations	$ 998	$ (7)	$ 1,425	$ (35)	$ 2,423	$ (42)
State and municipal obligations	1,334	(11)	2,491	(46)	3,825	(57)
Corporate obligations	8,105	(109)	4,239	(109)	12,344	(218)
U.S. agency mortgage-backed securities	1,296	(22)	2,388	(84)	3,684	(106)
Non-U.S. agency mortgage-backed securities	622	(7)	459	(13)	1,081	(20)
Total debt securities — available-for-sale	$12,355	$ (156)	$11,002	$ (287)	$23,357	$ (443)

The Company's unrealized losses from all securities as of December 31, 2019 were generated from approximately 3,000 positions out of a total of 31,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting no significant deterioration since purchase. As of December 31, 2019, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety 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.

The fair value hierarchy is summarized as follows:

Level 1—Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2—Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3—Unobservable inputs that cannot be corroborated by observable market data.

There were no transfers in or out of Level 3 financial assets or liabilities during the years ended December 31, 2019 or 2018.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2019 or 2018.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. 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 third-party pricing service (pricing service), which generally uses quoted 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 nonbinding 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 to the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds, which are not a significant portion of our investments, are estimated using valuation techniques that rely heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2019				
Cash and cash equivalents	$ 10,837	$ 148	$ —	$10,985
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,369	184	—	3,553
State and municipal obligations	—	5,926	—	5,926
Corporate obligations	70	17,923	249	18,242
U.S. agency mortgage-backed securities	—	6,528	—	6,528
Non-U.S. agency mortgage-backed securities	—	1,845	—	1,845
Total debt securities — available-for-sale	3,439	32,406	249	36,094
Equity securities	1,734	22	—	1,756
Assets under management	1,123	1,918	35	3,076
Total assets at fair value	$ 17,133	$ 34,494	$ 284	$51,911
Percentage of total assets at fair value	33%	66%	1%	100%
December 31, 2018				
Cash and cash equivalents	$ 10,757	$ 109	$ —	$10,866
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,060	345	—	3,405
State and municipal obligations	—	7,121	—	7,121
Corporate obligations	39	14,950	173	15,162
U.S. agency mortgage-backed securities	—	4,852	—	4,852
Non-U.S. agency mortgage-backed securities	—	1,358	—	1,358
Total debt securities — available-for-sale	3,099	28,626	173	31,898
Equity securities	1,832	13	—	1,845
Assets under management	1,086	1,938	8	3,032
Total assets at fair value	$ 16,774	$ 30,686	$ 181	$47,641
Percentage of total assets at fair value	35%	65%	—%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2019					
Debt securities — held-to-maturity	$ 541	$ 181	$ 253	$ 975	$ 972
Long-term debt and other financing obligations	$ —	$ 45,078	$ —	$ 45,078	$ 40,278
December 31, 2018					
Debt securities — held-to-maturity	$ 260	$ 65	$ 295	$ 620	$ 621
Long-term debt and other financing obligations	$ —	$ 37,944	$ —	$ 37,944	$ 36,554

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2019	December 31, 2018
Land and improvements	$ 589	$ 566
Buildings and improvements	4,705	4,470
Computer equipment	2,015	1,984
Furniture and fixtures	1,752	1,525
Less accumulated depreciation	(3,328)	(2,787)
Property and equipment, net	5,733	5,758
Capitalized software	4,638	4,054
Less accumulated amortization	(1,667)	(1,354)
Capitalized software, net	2,971	2,700
Total property, equipment and capitalized software, net	$ 8,704	$ 8,458

Depreciation expense for property and equipment for the years ended December 31, 2019, 2018 and 2017 was $995 million, $924 million and $799 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2019, 2018 and 2017 was $721 million, $606 million and $550 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptmRx	Consolidated
Balance at January 1, 2018	$ 24,484	$ 11,488	$ 5,674	$ 12,910	$ 54,556
Acquisitions	2,723	471	106	1,881	5,181
Foreign currency effects and adjustments, net	(807)	(12)	(8)	—	(827)
Balance at December 31, 2018	26,400	11,947	5,772	14,791	58,910
Acquisitions	1,022	3,395	2,521	6	6,944
Foreign currency effects and adjustments, net	(194)	—	(1)	—	(195)
Balance at December 31, 2019	$ 27,228	$ 15,342	$ 8,292	$ 14,797	$ 65,659

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

(in millions)	December 31, 2019 Gross Carrying Value	December 31, 2019 Accumulated Amortization	December 31, 2019 Net Carrying Value	December 31, 2018 Gross Carrying Value	December 31, 2018 Accumulated Amortization	December 31, 2018 Net Carying Value
Customer-related	$12,968	$ (4,319)	$ 8,649	$11,622	$ (3,908)	$7,714
Trademarks and technology	1,186	(525)	661	1,122	(512)	610
Trademarks and other indefinite-lived	726	—	726	745	—	745
Other	541	(228)	313	428	(172)	256
Total	$15,421	$ (5,072)	$10,349	$13,917	$ (4,592)	$9,325

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2019 Fair Value	2019 Weighted-Average Useful Life	2018 Fair Value	2018 Weighted-Average Useful Life
Customer-related	$1,750	13 years	$1,355	17 years
Trademarks and technology	163	5 years	122	4 years
Other	119	11 years	97	9 years
Total acquired finite-lived intangible assets	$2,032	13 years	$1,574	16 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2020	$1,017
2021	933
2022	826
2023	763
2024	718

Amortization expense relating to intangible assets for the years ended December 31, 2019, 2018 and 2017 was $1.0 billion, $898 million and $896 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2019	2018	2017
Medical costs payable, beginning of period	$ 19,891	$ 17,871	$ 16,391
Acquisitions	679	339	83
Reported medical costs:			
Current year	157,020	145,723	130,726
Prior years	(580)	(320)	(690)
Total reported medical costs	156,440	145,403	130,036
Medical payments:			
Payments for current year	(137,155)	(127,155)	(113,811)
Payments for prior years	(18,165)	(16,567)	(14,828)
Total medical payments	(155,320)	(143,722)	(128,639)
Medical costs payable, end of period	$ 21,690	$ 19,891	$ 17,871

For the years ended December 31, 2019 and 2017 medical cost reserve development was primarily driven by lower than expected health system utilization levels. For the year ended December 31, 2018, no individual factors significantly impacted medical cost reserve development.

Medical costs payable included IBNR of $13.8 billion and $13.2 billion at December 31, 2019 and 2018, respectively. Substantially all of the IBNR balance as of December 31, 2019 relates to the current year. The following is information about incurred and paid medical cost development as of December 31, 2019:

(in millions)	Net Incurred Medical Costs For the Years ended December 31,	
Year	2018	2019
2018	$ 145,723	$ 145,293
2019		157,020
Total		$ 302,313

(in millions)	Net Cumulative Medical Payments For the Years ended December 31,	
Year	2018	2019
2018	$ (127,155)	$ (144,143)
2019		(137,155)
Total		(281,298)
Net remaining outstanding liabilities prior to 2018		675
Total medical costs payable		$ 21,690

8. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2019			December 31, 2018		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 400	$ 400	$ 400	$ —	$ —	$ —
1.700% notes due February 2019	—	—	—	750	750	749
1.625% notes due March 2019	—	—	—	500	500	499
2.300% notes due December 2019	—	—	—	500	494	497
2.700% notes due July 2020	1,500	1,499	1,506	1,500	1,498	1,494
Floating rate notes due October 2020	300	300	300	300	299	298
3.875% notes due October 2020	450	450	455	450	443	456
1.950% notes due October 2020	900	899	900	900	897	884
4.700% notes due February 2021	400	403	410	400	398	412
2.125% notes due March 2021	750	749	753	750	747	734
Floating rate notes due June 2021	350	349	350	350	349	347
3.150% notes due June 2021	400	399	407	400	399	400
3.375% notes due November 2021	500	501	512	500	489	503
2.875% notes due December 2021	750	753	765	750	735	748
2.875% notes due March 2022	1,100	1,087	1,121	1,100	1,051	1,091
3.350% notes due July 2022	1,000	998	1,036	1,000	997	1,005
2.375% notes due October 2022	900	896	911	900	894	872
0.000% notes due November 2022	15	13	14	15	12	13
2.750% notes due February 2023	625	624	638	625	602	611
2.875% notes due March 2023	750	770	770	750	750	739
3.500% notes due June 2023	750	747	786	750	746	756
3.500% notes due February 2024	750	746	792	750	745	755
2.375% notes due August 2024	750	747	760	—	—	—
3.750% notes due July 2025	2,000	1,990	2,161	2,000	1,989	2,025
3.700% notes due December 2025	300	298	325	300	298	303
3.100% notes due March 2026	1,000	996	1,048	1,000	995	965
3.450% notes due January 2027	750	746	804	750	746	742
3.375% notes due April 2027	625	620	667	625	619	611
2.950% notes due October 2027	950	939	988	950	938	898
3.850% notes due June 2028	1,150	1,142	1,269	1,150	1,142	1,163
3.875% notes due December 2028	850	843	941	850	842	861
2.875% notes due August 2029	1,000	993	1,029	—	—	—
4.625% notes due July 2035	1,000	992	1,215	1,000	992	1,060
5.800% notes due March 2036	850	838	1,129	850	838	1,003
6.500% notes due June 2037	500	492	712	500	492	638
6.625% notes due November 2037	650	641	940	650	641	841
6.875% notes due February 2038	1,100	1,076	1,631	1,100	1,076	1,437
3.500% notes due August 2039	1,250	1,241	1,313	—	—	—
5.700% notes due October 2040	300	296	396	300	296	355
5.950% notes due February 2041	350	345	475	350	345	426
4.625% notes due November 2041	600	589	716	600	588	627
4.375% notes due March 2042	502	484	580	502	484	503
3.950% notes due October 2042	625	607	688	625	607	596
4.250% notes due March 2043	750	735	856	750	734	744
4.750% notes due July 2045	2,000	1,973	2,463	2,000	1,973	2,116
4.200% notes due January 2047	750	738	861	750	738	745
4.250% notes due April 2047	725	717	839	725	717	719
3.750% notes due October 2047	950	934	1,023	950	933	869
4.250% notes due June 2048	1,350	1,330	1,569	1,350	1,329	1,349
4.450% notes due December 2048	1,100	1,086	1,316	1,100	1,087	1,132
3.700% notes due August 2049	1,250	1,235	1,344	—	—	—
3.875% notes due August 2059	1,250	1,228	1,350	—	—	—
Total commercial paper and long-term debt	$39,817	$39,474	$44,234	$35,667	$35,234	$36,591

The Company's long-term debt obligations also included $1.2 billion and $1.3 billion of other financing obligations, of which $322 million and $229 million were current as of December 31, 2019 and 2018, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2020	$ 3,870
2021	3,325
2022	3,190
2023	2,300
2024	1,675
Thereafter	26,660

Commercial Paper and Revolving Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers.

The Company has $4.4 billion five-year, $4.4 billion three-year and $3.8 billion 364-day revolving bank credit facilities with 25 banks, which mature in December 2024, December 2022 and December 2020, respectively. These facilities provide liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2019, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2019, annual interest rates would have ranged from 2.4% to 2.6%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2019.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2019	2018	2017
Current Provision:			
Federal	$2,629	$2,897	$3,597
State and local	319	219	314
Foreign	564	404	254
Total current provision	3,512	3,520	4,165
Deferred provision (benefit)	230	42	(965)
Total provision for income taxes	$3,742	$3,562	$3,200

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2019		2018		2017	
Tax provision at the U.S. federal statutory rate	$3,776	21.0%	$3,348	21.0%	$ 4,908	35.0%
Change in tax law	—	—	—	—	(1,199)	(8.6)
State income taxes, net of federal benefit	271	1.5	168	1.0	197	1.4
Share-based awards — excess tax benefit	(132)	(0.7)	(161)	(1.0)	(319)	(2.3)
Non-deductible compensation	119	0.7	117	0.7	175	1.3
Health insurance industry tax	—	—	552	3.5	—	—
Foreign rate differential	(214)	(1.2)	(203)	(1.3)	(282)	(2.0)
Other, net	(78)	(0.5)	(259)	(1.6)	(280)	(2.0)
Provision for income taxes	$3,742	20.8%	$3,562	22.3%	$ 3,200	22.8%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2019	2018
Deferred income tax assets:		
Accrued expenses and allowances	$ 654	$ 551
U.S. federal and state net operating loss carryforwards	260	190
Share-based compensation	97	91
Nondeductible liabilities	184	184
Non-U.S. tax loss carryforwards	420	426
Lease liability	892	—
Other-domestic	179	306
Other-non-U.S.	329	337
Subtotal	3,015	2,085
Less: valuation allowances	(147)	(84)
Total deferred income tax assets	2,868	2,001
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,370)	(2,131)
Non-U.S. goodwill and intangible assets	(735)	(709)
Capitalized software	(683)	(603)
Depreciation and amortization	(301)	(266)
Prepaid expenses	(172)	(152)
Outside basis in partnerships	(317)	(300)
Lease right-of-use asset	(887)	—
Other-domestic	(177)	—
Other-non-U.S.	(219)	(314)
Total deferred income tax liabilities	(5,861)	(4,475)
Net deferred income tax liabilities	$(2,993)	$(2,474)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Federal net operating loss carryforwards of $62 million expire beginning in 2022 through 2037 and $179 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2020 through 2039, with some having an indefinite carryforward period. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2019, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2019	2018	2017
Gross unrecognized tax benefits, beginning of period	$1,056	$ 598	$ 263
Gross increases:			
Current year tax positions	512	487	356
Prior year tax positions	2	87	40
Gross decreases:			
Prior year tax positions	(96)	(84)	(33)
Settlements	(46)	(20)	(24)
Statute of limitations lapses	(5)	(12)	(4)
Gross unrecognized tax benefits, end of period	$1,423	$1,056	$ 598

The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $90 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2019, 2018 and 2017, the Company recognized $19 million, $6 million and $14 million of interest and penalties, respectively. The Company had $76 million and $95 million of accrued interest and penalties for uncertain tax positions as of December 31, 2019 and 2018, respectively. These amounts are not included in the reconciliation above. As of December 31, 2019, there were $852 million of unrecognized tax benefits that, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017, 2018 and 2019 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2014 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and HMO subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these state regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) under the capital adequacy rules to which it is subject. At December 31, 2019, the Company believes that Optum Bank met the FDIC requirements to be considered "Well Capitalized."

For the year ended December 31, 2019, the Company's regulated subsidiaries paid their parent companies dividends of $5.6 billion, including $1.3 billion of extraordinary dividends. For the year ended December 31, 2018, the Company's regulated subsidiaries paid their parent companies dividends of $3.7 billion, including $1.1 billion of extraordinary dividends.

The Company's regulated subsidiaries had estimated aggregate statutory capital and surplus of $22.7 billion as of December 31, 2019. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's regulated subsidiaries was approximately $9.7 billion as of December 31, 2019.

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2019 and 2018 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2019**	**2018**
Common share repurchases, shares	22	19
Common share repurchases, average price per share	$ 245.97	$ 236.72
Common share repurchases, aggregate cost	$ 5,500	$ 4,500
Board authorized shares remaining	72	94

Dividends

In June 2019, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $4.32 compared to $3.60 per share, which the Company had paid since June 2018. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options and restricted shares. As of December 31, 2019, the Company had 32 million shares available for future grants of share-based awards under the Plan. As of December 31, 2019, there were also 5 million shares of common stock available for issuance under the ESPP.

Stock Options

Stock option activity for the year ended December 31, 2019 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	35	$ 131		
Granted	7	260		
Exercised	(9)	94		
Forfeited	(1)	212		
Outstanding at end of period	32	166	6.5	$ 4,106
Exercisable at end of period	15	114	5.0	2,716
Vested and expected to vest, end of period	31	165	6.4	4,068

Restricted Shares

Restricted share activity for the year ended December 31, 2019 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	6	$ 163
Granted	2	259
Vested	(3)	147
Nonvested at end of period	5	207

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2019	2018	2017
Stock Options			
Weighted-average grant date fair value of shares granted, per share	$ 46	$ 43	$ 29
Total intrinsic value of stock options exercised	1,398	1,431	1,473
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	259	229	163
Total fair value of restricted shares vested	$ 545	$ 521	$ 460
Employee Stock Purchase Plan			
Number of shares purchased	1	2	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 697	$ 638	$ 597
Share-based compensation expense, net of tax effects	641	587	531
Income tax benefit realized from share-based award exercises	201	239	431

(in millions, except years)	December 31, 2019
Unrecognized compensation expense related to share awards	$ 714
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options were as follows:

	For the Years Ended December 31,		
	2019	2018	2017
Risk-free interest rate	1.5% - 2.5%	2.6% - 3.1%	1.9% - 2.1%
Expected volatility	19.4% - 21.6%	18.7% - 19.3%	18.5% - 20.7%
Expected dividend yield	1.4% - 1.8%	1.3% - 1.5%	1.4% - 1.6%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.3	5.6	5.7

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option exercises and forfeitures within the valuation model. The expected lives of options granted represents the period of time that the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2019, 2018 and 2017.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus and receive certain Company contributions on such deferrals, subject to plan limitations. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $1.4 billion and $988 million as of December 31, 2019 and 2018, respectively.

12. Commitments and Contingencies

Leases

Operating lease costs were $1.0 billion, $751 million and $710 million for the years ended December 31, 2019, 2018 and 2017, respectively, and included immaterial variable and short-term lease costs for the year ended December 31, 2019. Cash payments made on the Company's operating lease liabilities were $746 million for the year ended December 31, 2019, which were classified within operating activities in the Consolidated Statements of Cash Flows. As of December 31, 2019, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.6 years and 3.9%, respectively.

As of December 31, 2019, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2020	$ 804
2021	723
2022	604
2023	499
2024	402
Thereafter	1,671
Total future minimum lease payments	4,703
Less imputed interest	(744)
Total	$ 3,959

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2019, 2018 or 2017.

As of December 31, 2019, the Company had outstanding, undrawn letters of credit with financial institutions of $98 million and surety bonds outstanding with insurance companies of $1.2 billion, primarily to bond contractual performance.

Legal Matters

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. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

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.

Government Investigations, Audits and Reviews

The Company has been involved 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, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Similarly, our

international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

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 made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome that may result from this matter given its procedural status.

13. Business Combinations

During the year ended December 31, 2019, the Company completed several business combinations for total cash consideration of $9.9 billion.

The total consideration exceeded the estimated fair value of the net tangible assets acquired by $8.9 billion, of which $2.0 billion has been allocated to finite-lived intangible assets and $6.9 billion to goodwill. The goodwill is not deductible for income tax purposes.

Acquired tangible assets (liabilities) at acquisition date were:

(in millions)	
Cash and cash equivalents	$ 1,542
Accounts receivable and other current assets	1,788
Property, equipment and other long-term assets	1,969
Medical costs payable	(679)
Accounts payable and other current liabilities	(1,869)
Other long-term liabilities	(1,488)
Total net tangible assets	$ 1,263

The preliminary purchase price allocations for the various business combinations are subject to adjustment as valuation analyses, primarily related to intangible assets and contingent and tax liabilities, are finalized. See Note 6 for a summary of the acquisition date fair values and weighted-average useful lives assigned to acquired finite-lived intangible assets.

The results of operations and financial condition of acquired entities have been included in the Company's consolidated results and the results of the corresponding operating segment as of date of acquisition. Through December 31, 2019, acquired entities' impact on revenues and net earnings was not material.

Unaudited pro forma revenues for the years ended December 31, 2019 and 2018 as if the acquisitions had occurred on January 1, 2018 were immaterial for both periods. The pro forma effects of the acquisitions on net earnings were immaterial for both years.

14. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global is a diversified global health services business with a variety of offerings, including international commercial health and dental benefits and health care delivery.
- *OptumHealth* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. OptumHealth serves the physical, emotional and health-related financial needs of individuals, enabling population health through programs offered by employers, payers, government entities and directly with the care delivery system. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* provides services, technology and health care expertise to major participants in the health care industry. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations that comprise the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and community health pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Transactions with affiliated customers are eliminated in consolidation. Assets and liabilities that are jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned such that each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 33%, 30% and 28% for 2019, 2018 and 2017, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 96% of consolidated total revenues for 2019, 2018 and 2017. Long-lived fixed assets located in the United States represented approximately 72% and 76% of the total long-lived fixed assets as of December 31, 2019 and 2018, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
2019								
Revenues — unaffiliated customers:								
Premiums	$ 183,783	$ 5,916	$ —	$ —	$ —	$ 5,916	$ —	$ 189,699
Products	—	31	116	31,450	—	31,597	—	31,597
Services	8,922	5,732	3,630	689	—	10,051	—	18,973
Total revenues — unaffiliated customers	192,705	11,679	3,746	32,139	—	47,564	—	240,269
Total revenues — affiliated customers	—	17,966	6,239	42,093	(1,661)	64,637	(64,637)	—
Investment and other income	1,137	672	21	56	—	749	—	1,886
Total revenues	$ 193,842	$ 30,317	$ 10,006	$ 74,288	$ (1,661)	$112,950	$ (64,637)	$ 242,155
Earnings from operations	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ —	$ 19,685
Interest expense	—	—	—	—	—	—	(1,704)	(1,704)
Earnings before income taxes	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ (1,704)	$ 17,981
Total assets	$ 88,250	$ 40,444	$ 15,181	$ 36,346	$ —	$ 91,971	$ (6,332)	$ 173,889
Purchases of property, equipment and capitalized software	841	573	495	162	—	1,230	—	2,071
Depreciation and amortization	926	565	672	557	—	1,794	—	2,720
2018								
Revenues — unaffiliated customers:								
Premiums	$ 174,282	$ 3,805	$ —	$ —	$ —	$ 3,805	$ —	$ 178,087
Products	—	52	111	29,438	—	29,601	—	29,601
Services	8,366	4,925	3,280	612	—	8,817	—	17,183
Total revenues — unaffiliated customers	182,648	8,782	3,391	30,050	—	42,223	—	224,871
Total revenues — affiliated customers	—	14,882	5,596	39,440	(1,409)	58,509	(58,509)	—
Investment and other income	828	481	21	46	—	548	—	1,376
Total revenues	$ 183,476	$ 24,145	$ 9,008	$ 69,536	$ (1,409)	$101,280	$ (58,509)	$ 226,247
Earnings from operations	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ —	$ 17,344
Interest expense	—	—	—	—	—	—	(1,400)	(1,400)
Earnings before income taxes	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ (1,400)	$ 15,944
Total assets	$ 82,938	$ 29,837	$ 11,039	$ 33,912	$ —	$ 74,788	$ (5,505)	$ 152,221
Purchases of property, equipment and capitalized software	761	593	517	192	—	1,302	—	2,063
Depreciation and amortization	845	439	654	490	—	1,583	—	2,428
2017								
Revenues — unaffiliated customers:								
Premiums	$ 154,709	$ 3,744	$ —	$ —	$ —	$ 3,744	$ —	$ 158,453
Products	—	44	106	26,216	—	26,366	—	26,366
Services	7,890	4,013	2,849	565	—	7,427	—	15,317
Total revenues — unaffiliated customers	162,599	7,801	2,955	26,781	—	37,537	—	200,136
Total revenues — affiliated customers	—	12,429	5,127	36,954	(1,227)	53,283	(53,283)	—
Investment and other income	658	340	5	20	—	365	—	1,023
Total revenues	$ 163,257	$ 20,570	$ 8,087	$ 63,755	$ (1,227)	$ 91,185	$ (53,283)	$ 201,159
Earnings from operations	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ —	$ 15,209
Interest expense	—	—	—	—	—	—	(1,186)	(1,186)
Earnings before income taxes	$ 8,498	$ 1,823	$ 1,770	$ 3,118	$ —	$ 6,711	$ (1,186)	$ 14,023
Total assets	$ 76,676	$ 26,931	$ 11,273	$ 29,551	$ —	$ 67,755	$ (5,373)	$ 139,058
Purchases of property, equipment and capitalized software	737	510	588	188	—	1,286	—	2,023
Depreciation and amortization	758	380	614	493	—	1,487	—	2,245

15. Quarterly Financial Data (Unaudited)

Selected quarterly financial information for all quarters of 2019 and 2018 is as follows:

(in millions, except per share data)	For the Quarter Ended March 31	June 30	September 30	December 31
2019				
Revenues	$ 60,308	$ 60,595	$ 60,351	$ 60,901
Operating costs	55,476	55,851	55,337	55,806
Earnings from operations	4,832	4,744	5,014	5,095
Net earnings	3,557	3,385	3,629	3,668
Net earnings attributable to UnitedHealth Group common shareholders	3,467	3,293	3,538	3,541
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	3.62	3.47	3.73	3.74
Diluted	3.56	3.42	3.67	3.68
2018				
Revenues	$ 55,188	$ 56,086	$ 56,556	$ 58,417
Operating costs	51,135	51,882	51,966	53,920
Earnings from operations	4,053	4,204	4,590	4,497
Net earnings	2,924	3,010	3,284	3,164
Net earnings attributable to UnitedHealth Group common shareholders	2,836	2,922	3,188	3,040
Net earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	2.94	3.04	3.31	3.16
Diluted	2.87	2.98	3.24	3.10

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2019. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2019.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2019 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2019

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2019. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control-Integrated Framework (2013).* Based on our assessment and the COSO criteria, we believe that, as of December 31, 2019, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2019, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2019, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2019, of the Company and our report dated February 14, 2020, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2019. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 14, 2020

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of February 14, 2020, including their name and principal occupation or employment:

William C. Ballard, Jr.
Former Of Counsel
Bingham Greenebaum Doll LLP

Richard T. Burke
Lead Independent Director
UnitedHealth Group

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Chair
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie Montgomery Rice, M.D.
President and Dean
Morehouse School of Medicine

John H. Noseworthy, M.D.
Former Chief Executive Officer and President
Mayo Clinic

Glenn M. Renwick
Former Chairman and Chief Executive Officer
The Progressive Corporation

David S. Wichmann
Chief Executive Officer
UnitedHealth Group

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401 of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at *www.unitedhealthgroup.com*. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance," "Proposal 1-Election of Directors" and "Delinquent Section 16(a) Reports" in our definitive proxy statement for our 2020 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402 and 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and "Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2020 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

Equity Compensation Plan Information

The following table sets forth certain information, as of December 31, 2019, concerning shares of common stock authorized for issuance under all of our equity compensation plans:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(in millions)		(in millions)
Equity compensation plans approved by shareholders [1]	31	$ 169	37[3]
Equity compensation plans not approved by shareholders [2]	—	—	—
Total [2]	31	$ 169	37

(1) Consists of the UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and the UnitedHealth Group 1993 Employee Stock Purchase Plan, as amended.

(2) Excludes 824,000 shares underlying stock options assumed by us in connection with acquisitions. These options have a weighted-average exercise price of $58 and an average remaining term of approximately 4 years. These options are administered pursuant to the terms of the plans under which the options originally were granted. No future awards will be granted under these acquired plans.

(3) Includes 5 million shares of common stock available for future issuance under the 1993 Employee Stock Purchase Plan as of December 31, 2019, and 32 million shares available under the 2011 Stock Incentive Plan as of December 31, 2019. Shares available under the 2011 Stock Incentive Plan may become the subject of future awards in the form of stock options, stock appreciation rights, restricted stock, restricted stock units, performance awards and other stock-based awards.

The information required by Item 403 of Regulation S-K will be included under the heading "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2020 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2020 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2020 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements and Supplementary Data*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2019 and 2018.
- Consolidated Statements of Operations for the years ended December 31, 2019, 2018, and 2017.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2019, 2018, and 2017.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2019, 2018, and 2017.
- Consolidated Statements of Cash Flows for the years ended December 31, 2019, 2018, and 2017.
- *Notes to the Consolidated Financial Statements.*

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Bylaws of UnitedHealth Group Incorporated, effective August 15, 2017 (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on August 16, 2017)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)

4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
4.5	Description of Common Stock
*10.1	UnitedHealth Group Incorporated 2011 Stock Incentive Plan, as amended and restated in 2018 (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2018)
*10.2	Amendment to UnitedHealth Group Incorporated's Stock Option and Stock Appreciation Right Awards, effective November 6, 2014 (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2014)
*10.3	Form of Agreement for Non-Qualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.4	Form of Agreement for Non-Qualified Stock Option Award for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
*10.5	Form of Addendum for Non-Qualified Stock Option Award Agreement for International Participants under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.37 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.6	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.7	Form of Agreement for Restricted Stock Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.8	Form of Agreement for Stock Appreciation Rights Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.9	Form of Agreement for Performance-based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan, as amended and restated in 2015, for awards made after January 1, 2016 (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)

*10.10	Form of Agreement for Initial Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.7 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
*10.11	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2011 Stock Incentive Plan (incorporated by reference to Exhibit 10.6 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on May 27, 2011)
10.12	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.13	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.15	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.16	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.17	UnitedHealth Group Executive Savings Plan (2020 Statement)
*10.18	Summary of Non-Management Director Compensation, effective as of November 8, 2019
*10.19	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.20	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.21	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.22	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.23	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.24	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)

*10.25	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.26	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.27	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.28	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.29	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.30	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.31	Employment Agreement, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.32	Agreement for Supplemental Executive Retirement Pay, effective April 1, 2004, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10(b) to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2004)
*10.33	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of November 7, 2006, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit A to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on November 8, 2006)
*10.34	Amendment to Employment Agreement and Agreement for Supplemental Executive Retirement Pay, effective as of December 31, 2008, between United HealthCare Services, Inc. and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.35	Amendment to Agreement for Supplemental Executive Retirement Pay, dated as of June 7, 2016, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.36	Letter Agreement, effective as of February 19, 2008, by and between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.22 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2007)
*10.37	Amendment to Employment Agreement, dated as of December 14, 2010, between UnitedHealth Group Incorporated and Stephen J. Hemsley (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on December 15, 2010)

*10.38	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.39	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.40	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.41	Amended and Restated Employment Agreement, effective as of March 24, 2015, between United HealthCare Services, Inc. and Steven H. Nelson (incorporated by reference to Exhibit 10.51 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2017)
*10.42	Separation and Release Agreement, effective as of September 30, 2019, between Steven H. Nelson and United HealthCare Services, Inc. (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019)
*10.43	Employment Agreement, effective as of June 3, 2018, between United HealthCare Services, Inc. and Andrew Witty (incorporated by reference to Exhibit 10.50 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2018)
*10.44	Amended and Restated Employment Agreement, effective as of March 16, 2015, between United HealthCare Services, Inc. and Dirk McMahon
*10.45	Amendment to Employment Agreement, effective as of May 31, 2017, between United HealthCare Services, Inc. and Dirk McMahon
*10.46	Amendment to Employment Agreement, effective as of March 12, 2019, between United HealthCare Services, Inc. and Dirk McMahon
*10.47	Employment Agreement, effective as of January 1, 2013, between United HealthCare Services, Inc. and Marianne D. Short (incorporated by reference to Exhibit 10.34 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2013)
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data")
21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document—the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.

101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.
104	Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101).

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* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2019 and 2018, and for each of the three years in the period ended December 31, 2019, and the Company's internal control over financial reporting as of December 31, 2019, and have issued our reports thereon dated February 14, 2020; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
February 14, 2020

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2019	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 46	$ 434
Other current assets	787	197
Total current assets	833	631
Equity in net assets of subsidiaries	93,467	83,244
Long-term notes receivable from subsidiaries	5,079	4,461
Other assets	794	972
Total assets	$ 100,173	$ 89,308
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 688	$ 618
Current portion of notes payable to subsidiaries	750	714
Commercial paper and current maturities of long-term debt	3,548	1,744
Total current liabilities	4,986	3,076
Long-term debt, less current maturities	35,926	33,490
Long-term notes payable to subsidiaries	1,314	560
Other liabilities	331	486
Total liabilities	42,557	37,612
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 948 and 960 issued and outstanding	9	10
Additional paid-in capital	7	—
Retained earnings	61,178	55,846
Accumulated other comprehensive loss	(3,578)	(4,160)
Total UnitedHealth Group shareholders' equity	57,616	51,696
Total liabilities and shareholders' equity	$ 100,173	$ 89,308

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2019	2018	2017
Revenues:			
Investment and other income	$ 209	$ 194	$ 527
Total revenues	209	194	527
Operating costs:			
Operating costs	38	35	—
Interest expense	1,580	1,285	1,114
Total operating costs	1,618	1,320	1,114
Loss before income taxes	(1,409)	(1,126)	(587)
Benefit for income taxes	293	251	214
Loss of parent company	(1,116)	(875)	(373)
Equity in undistributed income of subsidiaries	14,955	12,861	10,931
Net earnings	13,839	11,986	10,558
Other comprehensive income (loss)	582	(1,517)	14
Comprehensive income	$14,421	$10,469	$10,572

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2019	2018	2017
Operating activities			
Cash flows from operating activities	$9,275	$6,099	$2,021
Investing activities			
Issuances of notes to subsidiaries	(2,722)	(1,420)	—
Repayments of notes to subsidiaries	2,249	1,419	2,071
Cash paid for acquisitions	(9,645)	(4,066)	(2,313)
Return of capital to parent company	4,497	4,196	3,375
Capital contributions to subsidiaries	(803)	(1,259)	(959)
Other, net	490	4	—
Cash flows (used for) from investing activities	(5,934)	(1,126)	2,174
Financing activities			
Common stock repurchases	(5,500)	(4,500)	(1,500)
Proceeds from common stock issuances	1,037	838	688
Cash dividends paid	(3,932)	(3,320)	(2,773)
Proceeds from (repayments of) commercial paper, net	300	(201)	(3,508)
Proceeds from issuance of long-term debt	5,444	6,935	5,291
Repayments of long-term debt	(1,750)	(2,600)	(3,472)
Proceeds (repayments) of notes from subsidiaries	1,207	(1,127)	1,704
Other, net	(535)	(923)	(446)
Cash flows used for financing activities	(3,729)	(4,898)	(4,016)
(Decrease) increase in cash and cash equivalents	(388)	75	179
Cash and cash equivalents, beginning of period	434	359	180
Cash and cash equivalents, end of period	$ 46	$ 434	$ 359
Supplemental cash flow disclosures			
Cash paid for interest	$1,506	$1,294	$1,062
Cash paid for income taxes	2,590	2,379	3,455
Supplemental schedule of non-cash investing activities			
Common stock issued for acquisitions	$ —	$ —	$2,164
Conversion of note receivable from subsidiaries to equity	—	—	4,378

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $5.6 billion, $5.6 billion and $3.4 billion in 2019, 2018 and 2017, respectively. Additionally, $4.5 billion, $4.2 billion and $3.4 billion in cash were received as a return of capital to the parent company during 2019, 2018 and 2017, respectively.

3. Commercial Paper and Long-Term Debt

Discussion of commercial paper and long-term debt can be found in Note 8 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries that totaled $1.2 billion and $1.3 billion at December 31, 2019 and 2018, respectively.

Maturities of commercial paper and long-term debt for the years ending December 31 are as follows:

(in millions)	
2020	$ 3,550
2021	3,150
2022	3,015
2023	2,125
2024	1,500
Thereafter	26,477

4. Commitments and Contingencies

For a summary of commitments and contingencies, see Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements and Supplementary Data."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 14, 2020

UNITEDHEALTH GROUP INCORPORATED

By /s/ DAVID S. WICHMANN

David S. Wichmann
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ DAVID S. WICHMANN **David S. Wichmann**	Director and Chief Executive Officer (principal executive officer)	February 14, 2020
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	February 14, 2020
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	February 14, 2020
* **William C. Ballard, Jr.**	Director	February 14, 2020
* **Richard T. Burke**	Director	February 14, 2020
* **Timothy P. Flynn**	Director	February 14, 2020
* **Stephen J. Hemsley**	Director	February 14, 2020
* **Michele J. Hooper**	Director	February 14, 2020
* **F. William McNabb III**	Director	February 14, 2020
* **Valerie C. Montgomery Rice, M.D.**	Director	February 14, 2020
* **John H. Noseworthy, M.D.**	Director	February 14, 2020
* **Glenn M. Renwick**	Director	February 14, 2020
* **Gail R. Wilensky, Ph.D.**	Director	February 14, 2020

*By /s/ MARIANNE D. SHORT

Marianne D. Short,
As Attorney-in-Fact

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2020

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated

(Exact name of registrant as specified in its charter)

Delaware	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center **9900 Bren Road East** **Minnetonka, Minnesota**	**55343**
(Address of principal executive offices)	**(Zip Code)**

(952) 936-1300

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $.01 par value	**UNH**	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one)

Large accelerated filer ☒
Non-accelerated filer ☐
Accelerated filer ☐
Smaller reporting company ☐
Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

The aggregate market value of voting stock held by non-affiliates of the registrant as of June 30, 2020 was $281,771,756,077 (based on the last reported sale price of $294.95 per share on June 30, 2020, on the New York Stock Exchange), excluding only shares of voting stock held beneficially by directors, executive officers and subsidiaries of the registrant.

As of January 29, 2021, there were 945,319,404 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to its 2021 Annual Meeting of Shareholders. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. BUSINESS

INTRODUCTION

Overview

The terms "we," "our," "us," "its," "UnitedHealth Group," or the "Company" used in this report refer to UnitedHealth Group Incorporated and its subsidiaries.

UnitedHealth Group is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone.

- We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities.
- We work 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.
- We support the patient-physician relationship and empower people with the information, guidance and tools they need to make personal health choices and decisions.

Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve. The breadth and scope of our diversified company help to consistently improve health care quality, access and affordability. Our ability to analyze complex data and apply deep health care expertise and insights allows us to serve people, care providers, businesses, communities and governments with more innovative products and complete, end-to-end offerings for many of the biggest challenges facing health care today.

Optum is an information and technology-enabled health services businesses delivering services to help modernize the health system and improve overall population health. Optum serves the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units to help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance, leveraging distinctive capabilities in data and analytics, pharmacy care services, population health, health care delivery and health care operations.

UnitedHealthcare offers a full spectrum of health benefit programs. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and individual consumers. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.

Through Optum and UnitedHealthcare, in 2020, we processed nearly a trillion dollars in gross billed charges and we managed more than $250 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; product revenues from pharmacy care services; fees from care delivery, management, administrative, technology, consulting and managed outsourced services; sales of a wide variety of products and services related to the broad health care industry; and investment and other income. Our two business platforms have four reportable segments:

- OptumHealth;
- OptumInsight;

- OptumRx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global.

Optum

Optum is an information and technology-enabled health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians, practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: employers; health plans; and state, federal and municipal agencies devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.
- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines to improve care delivery and health outcomes.

Optum operates three business segments leveraging distinctive capabilities in health care delivery, population health, health care operations, data and analytics and pharmacy care services:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, and health financial services;
- OptumInsight offers data, analytics, research, consulting, technology and managed services solutions; and
- OptumRx provides a diversified array of pharmacy care services.

OptumHealth

OptumHealth provides health and wellness care, addressing the physical, emotional and health-related financial needs of 98 million consumers, through a national health care delivery platform which engages people in the most appropriate care settings, including their homes. OptumHealth helps patients and providers navigate and address complex, chronic and behavioral health needs; delivers local primary, specialty, surgical and urgent care; offers post-acute care planning services; and serves consumers and care providers through advanced, on-demand digital health technologies, such as telehealth and remote patient monitoring, and innovative health care financial services. OptumHealth works directly with consumers, care delivery systems, employers, payers, and government entities to improve quality, patient and provider satisfaction while lowering cost.

OptumHealth enables care providers' transition from traditional fee-for-service payment models to performance-based delivery and payment models to improve patient health and outcomes. Through strategic partnerships, alliances and ownership arrangements, OptumHealth helps care providers adopt new approaches and technologies improving the coordination of care across providers to more comprehensively serve patients.

Optum Financial, including Optum Bank, serves consumers through 7.6 million health savings and other accounts and has more than $16 billion in assets under management as of December 31, 2020. During 2020, Optum Financial processed $178 billion in digital medical payments to physicians and other health care providers. Organizations across the health system rely on Optum to manage and improve payment flows through its highly automated, scalable, digital payment systems.

OptumHealth offers its products on a risk basis, assuming responsibility for health care costs in exchange for a monthly premium, on an administrative fee basis, managing or administering products and services in exchange for a monthly fee, or on a fee-for-service basis, delivering medical services to patients in exchange for a contracted fee. For financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three key areas: employers including large, mid-sized and small employers; payers including health plans, TPAs, underwriter/stop-loss carriers and individual product intermediaries; and government entities including the U.S. Departments of Health and Human Services (HHS), Veterans Affairs, Defense, and other federal, state and local health care agencies.

OptumInsight

OptumInsight brings together advanced analytics, technology and health care expertise to deliver integrated services and solutions. Hospital systems, physicians, health plans, state governments, life sciences companies and other organizations comprising the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, advance quality, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system. OptumInsight serves the needs of health systems (e.g., physicians and hospital systems), health plans, state governments and life sciences companies.

Health Systems. Serves hospitals, physicians and other care providers to improve revenue and growth, better coordinate care and reduce administrative costs through technology and services to improve population health management, patient engagement, revenue cycle management and strategic growth plans.

Health Plans. Serves health plans by improving financial performance and enhancing outcomes through proactive analytics, a comprehensive payment integrity portfolio and staff-supported risk and quality services. OptumInsight helps health plans navigate a dynamic environment defined by shifts in employer vs. government-sponsored coverage, the demand for affordable benefit plans and the need to leverage new technology to reduce complexity.

State Governments. Provides advanced technology and analytics services to modernize the administration of critical safety net programs, such as Medicaid, while improving cost predictability.

Life Sciences Companies. Combines data and analytics expertise with comprehensive technologies and health care knowledge to help life sciences companies adopt a more comprehensive approach to advancing therapeutic discoveries and improving clinical outcomes.

Many of OptumInsight's software and information products and professional services are delivered over extended periods, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog as of December 31, 2020 was approximately $20.2 billion, of which $10.5 billion is expected to be realized within the next 12 months. The aggregate backlog includes $7.5 billion related to affiliated agreements. OptumInsight's aggregate backlog as of December 31, 2019, was $19.3 billion. OptumInsight cannot provide any assurance it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumRx

OptumRx provides a full spectrum of pharmacy care services through its network of more than 67,000 retail pharmacies, multiple home delivery, specialty and community health pharmacies and through the provision of in-home and pharmacy infusion services. OptumRx manages limited and ultra-limited distribution drugs in oncology, HIV, pain management and ophthalmology and serves the growing pharmacy needs of people with behavioral health and substance use disorders, particularly Medicare and Medicaid beneficiaries.

OptumRx's comprehensive whole-person approach to pharmacy care services integrates demographic, medical, laboratory, pharmaceutical and other clinical data and applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individual consumers through enhanced services, elevated clinical quality and cost trend management.

In 2020, OptumRx managed $105 billion in pharmaceutical spending, including $46 billion in specialty pharmaceutical spending.

OptumRx serves health benefits providers, large national employer plans, unions and trusts, purchasing coalitions and government entities. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

OptumRx offers multiple clinical programs, digital tools and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner which are designed to promote better health outcomes, and to help target inappropriate utilization and non-adherence to medication, each of which may result in adverse medical events affecting member health and client pharmacy and medical spend. OptumRx provides various utilization management, medication management, quality assurance, adherence and counseling programs to complement each client's plan design and clinical strategies. OptumRx offers a distinctive approach to integrating the management of medical and pharmaceutical care by using data and advanced analytics to help improve comprehensive decision-making, elevate quality, close gaps in care and reduce costs for customers and people served.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, creating a better health care experience for its customers and helping to control rising health care costs. UnitedHealthcare's market position is built on:

- strong local-market relationships;
- the breadth of product offerings, based upon extensive expertise in distinct market segments in health care;
- service and advanced technology, including digital consumer engagement;
- competitive medical and operating cost positions;
- effective clinical engagement; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate and provide patient care, improve affordability of medical care, analyze cost trends, manage pharmacy care services, work with care providers more effectively and create a simpler and more satisfying consumer and physician experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks which, as of December 31, 2020, include 1.4 million physicians and other health care professionals and more than 6,500 hospitals and other facilities.

UnitedHealthcare is subject to extensive government regulation. See further discussion of our regulatory environment below under "Government Regulation" and in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers a comprehensive array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, and individual consumers. As of December 31, 2020, UnitedHealthcare Employer & Individual provides access to medical services for 26.2 million people on behalf of our customers and alliance partners, including employer customers, serving people across all 50 states, the District of Columbia and most U.S. territories. Products are offered through affiliates licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers who elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision.

The consolidated purchasing capacity represented by the individuals served by UnitedHealth Group makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities. UnitedHealthcare Employer & Individual has relationships with network care providers who integrate data and analytics, implement value-based payments and care management programs and enable us to jointly better manage health care and improve quality across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies who contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers. In addition, UnitedHealthcare Employer & Individual distributes its products through professional employer organizations, associations and through both multi-carrier and its own proprietary private exchange marketplaces.

UnitedHealthcare Employer & Individual's diverse product portfolio offers employers a continuum of benefit designs, price points and approaches to consumer engagement which provides the flexibility to meet a full spectrum of their coverage needs.

UnitedHealthcare Employer & Individual's major product families include:

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings

accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs, consumer education and other digital offerings. We also offer and have been developing a variety of innovative consumer-centric products aligning with the unique needs and financial means of our customers, while engaging individuals in better managing their health.

Traditional Products. Traditional products include a full range of medical benefits and network options, and offer a spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy care services products which complement its service offerings by improving quality of care, engaging consumers and providing cost-saving options. Consumers served by UnitedHealthcare Employer & Individual can access clinical products to help them make better health care decisions and better use of their medical benefits which contribute to improved health and lowered medical expenses.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmacy care services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs offering improved value and outcomes, helping consumers take actions to improve their health and supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on offering type (risk-based or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individual consumers) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including biometrics and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

Specialty Offerings. Through its broad network, UnitedHealthcare Employer & Individual delivers dental, vision, hearing and other specialty benefits, including accident protection, critical illness, disability and hospital indemnity offerings, using an integrated approach in private and retail settings.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older people. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products allowing people choice in obtaining the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) programs to supplement their government-sponsored Medicare by providing additional benefits and coverage options. UnitedHealthcare Medicare & Retirement services include care management and health system navigator services, clinical management programs, nurse health line services, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients, including AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through agents, employer groups and digital channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by the Centers for Medicare & Medicaid Services (CMS), including Medicare Advantage HMO plans, Preferred Provider Organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and Special Needs Plans (SNPs). Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, monthly consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which individuals reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. Medicare Advantage plans are designed to compete at the local level, taking into account consumer and care provider preferences, competitor offerings, our quality and cost initiatives, our historical financial results and the long-term payment rate outlook for each geographic area. UnitedHealthcare Medicare & Retirement served 5.7 million people through its Medicare Advantage products as of December 31, 2020.

Built on more than 20 years of experience, UnitedHealthcare Medicare & Retirement's senior-focused care management model operates at a medical cost level below traditional Medicare, while helping seniors live healthier lives. We have continued to enhance our offerings, focusing on more digital and physical care resources in the home, expanding our concierge navigation services and enabling the home as a safe and effective setting of care. For example, through our HouseCalls program, nurse practitioners performed nearly 1.7 million preventive care visits in 2020 to address unmet care opportunities and close gaps in care. Our Navigate4Me program provides a single point of contact and a direct line of support for individuals as they go through their health care experiences. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software and digital therapeutics for remote monitoring enabling clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information bridging across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify people at high risk and enable care managers to create individualized care plans to help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. The stand-alone Medicare Part D plans address a large spectrum of people's needs and preferences for their prescription drug coverage, including low-cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2020, UnitedHealthcare enrolled 9.2 million people in the Medicare Part D programs, including 4.0 million individuals in stand-alone Medicare Part D plans, with the remainder in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving 4.5 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at a diversity of price points. These products cover various levels of coinsurance and deductible gaps to which seniors are exposed in the traditional Medicare program.

Premium revenues from CMS represented 36% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2020, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs caring for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, typically in exchange for a monthly premium per member from the state program. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, including Temporary Assistance to Needy Families (TANF); Children's Health Insurance Programs (CHIP); Dual SNPs (DSNPs); Long-Term Services and Supports (LTSS); Aged, Blind and Disabled; and other federal, state and community health care programs. As of December 31, 2020, UnitedHealthcare Community & State participated in programs in 31 states and the District of Columbia, and served 6.6 million people; including more than 1.1 million people through Medicaid expansion programs in 16 states under the Patient Protection and Affordable Care Act (ACA).

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates, commensurate with medical cost trends.

These health plans and care programs are designed to address the complex needs of the populations they serve, including the chronically ill, people with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in medically underserved areas and are less likely to have a consistent relationship with the medical community or a care provider. They also often face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care and often addresses other social determinants affecting people's health status and health system usage.

Approximately 75% of the people in state Medicaid programs are served by managed care, but this population represents only approximately 50% of total Medicaid spending. UnitedHealthcare Community & State's business development opportunities include entering fee-for-service markets converting to managed care; and growing in existing managed care markets, including state expansions to populations with more complex needs requiring more sophisticated models of care, including DSNP and LTSS programs. Our offerings to state expansion cover more medically complex populations, including integrated care management of physical, behavioral, long-term care services and supports, and social services by applying strong data analytics and community-based collaboration.

UnitedHealthcare Community & State continues to evolve its clinical model to enhance quality and the clinical experience for the people it serves. The model enables UnitedHealthcare Community & State to quickly identify the people who could benefit most from more highly coordinated care.

UnitedHealthcare Global

UnitedHealthcare Global serves 7.6 million people with medical and dental benefits, typically in exchange for a monthly premium per member, residing principally in Brazil, Chile, Colombia and Peru, but also in 150 other countries. UnitedHealthcare Global serves multinational and local businesses, governments, insurers and individuals and their families through health insurance plans for local populations, care delivery services, benefit plans and risk and assistance solutions. UnitedHealthcare Global offers health care delivery in our principal markets through over 50 hospitals, and approximately 200 outpatient and ambulatory clinics and surgery centers to UnitedHealthcare Global members and consumers served by the external payer market.

In Brazil, Amil provides health benefits to 3.4 million people and dental benefits to more than 2.2 million people. Empresas Banmédica provides health benefits and health care services to approximately 2 million people in Chile, Colombia and Peru. Lusíadas Saúde provides clinical services to people in Portugal through an owned network of hospitals and outpatient clinics.

GOVERNMENT REGULATION

Our businesses are subject to comprehensive federal, state and international laws and regulations. We are regulated by federal, state and international regulatory agencies who generally have discretion to issue regulations and interpret and enforce laws and rules. The regulations can vary significantly from jurisdiction to jurisdiction and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals which could materially impact certain aspects of the health care system. New laws, regulations and rules, or changes in the interpretation of existing laws, regulations and rules, including as a result of changes in the political climate, could adversely affect our business.

If we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable laws, regulations and rules, our business, results of operations, financial position and cash flows could be materially and adversely affected. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to our compliance with federal, state and international laws and regulations.

Federal Laws and Regulation

We are subject to various levels of U.S. federal regulation. For example, when we contract with the federal government, we are subject to federal laws and regulations relating to the award, administration and performance of U.S. government contracts. CMS regulates our UnitedHealthcare businesses and certain aspects of our Optum businesses. Payments by CMS to our businesses are subject to regulations, including those governing fee-for-service and the submission of information relating to the health status of enrollees for purposes of determining the amounts of certain payments to us. CMS also has the right to audit our performance to determine our compliance with CMS contracts and regulations and the quality of care we provide to Medicare beneficiaries. Our commercial business is further subject to CMS audits related to medical loss ratios (MLRs) and risk adjustment data.

UnitedHealthcare Community & State has Medicaid and CHIP contracts subject to federal regulations regarding services to be provided to Medicaid enrollees, payment for those services and other aspects of these programs. There are many regulations affecting Medicare and Medicaid compliance and the regulatory environment with respect to these programs is complex. In addition, our business is subject to laws and regulations relating to consumer protection, anti-fraud and abuse, anti-kickbacks, false claims, prohibited referrals, inappropriate reduction or limitation of health care services, anti-money laundering, securities and antitrust compliance.

Privacy, Security and Data Standards Regulation. Certain of our operations are subject to regulation under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), which apply to both the group and individual health insurance markets, including self-funded employee benefit plans. Federal regulations related to HIPAA contain minimum standards for electronic transactions and code sets and for the privacy and security of protected health information.

Our businesses must comply with the Health Information Technology for Economic and Clinical Health Act (HITECH) which regulates matters relating to privacy, security and data standards. HITECH imposes requirements on uses and disclosures of health information; included contracting requirements for HIPAA business associate agreements; extends parts of HIPAA privacy and security provisions to business associates; adds federal data breach notification requirements for covered entities and business associates and reporting requirements to HHS and the Federal Trade Commission (FTC) and, in some cases, to the local media; strengthens enforcement and imposes higher financial penalties for HIPAA violations and, in certain cases, imposes criminal penalties for individuals, including employees. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The use and disclosure of individually identifiable health data by our businesses is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act (GLBA) or state statutes implementing GLBA. These federal laws and state statutes generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and generally prescribe safeguards for the protection of personal information. Neither the GLBA nor HIPAA privacy regulations preempt more stringent state laws and regulations, which may apply to us, as discussed below. Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

ERISA. The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how our services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to periodic interpretation by the U.S. Department of Labor (DOL) as well as the federal courts. ERISA sets forth standards on how our business units may do business with employers who sponsor employee health benefit plans, particularly those who maintain self-funded plans. Regulations established by the DOL subject us to additional requirements for administration of benefits, claims payment and member appeals under health care plans governed by ERISA.

State Laws and Regulation

Health Care Regulation. Our insurance and HMO subsidiaries must be licensed by the jurisdictions in which they conduct business. All of the states in which our subsidiaries offer insurance and HMO products regulate those products and operations. The states require periodic financial reports and establish minimum capital or restricted cash reserve requirements. The National Association of Insurance Commissioners (NAIC) has adopted model regulations which where adopted by states, require expanded governance practices and risk and solvency assessment reporting. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are required to maintain a risk management framework and file a confidential self-assessment report with state insurance regulators. We file reports annually with Connecticut, our lead regulator, and with New York, as required by the state's regulation. Certain states have also adopted their own regulations for minimum MLRs with which health plans must comply. In addition, a number of state legislatures have enacted or are contemplating significant reforms of their health insurance markets, either independent of or to comply with or be eligible for grants or other incentives in connection with the ACA, which may affect our operations and our financial results.

Our health plans and insurance companies are regulated under state insurance holding company regulations. Such regulations generally require registration with applicable state departments of insurance and the filing of reports

describing capital structure, ownership, financial condition, certain affiliated transactions and general business operations. Most state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material affiliated transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. These laws may restrict the ability of our regulated subsidiaries to pay dividends to our holding companies.

Some of our business activity is subject to other health care-related regulations and requirements, including PPO, Managed Care Organization (MCO), utilization review (UR), TPA, pharmacy care services, durable medical equipment or care provider-related regulations and licensure requirements. These regulations differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations which set specific standards for delivery of services, appeals, grievances and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices and covered benefits and services. State health care anti-fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services and improper marketing. Certain of our businesses are subject to state general agent, broker and sales distribution laws and regulations. UnitedHealthcare Community & State and certain of our Optum businesses are subject to regulation by state Medicaid agencies who oversee the provision of benefits to our Medicaid and CHIP beneficiaries and to our dually eligible (for Medicare and Medicaid) beneficiaries. We also contract with state governmental entities and are subject to state laws and regulations relating to the award, administration and performance of state government contracts.

State Privacy and Security Regulations. A number of states have adopted laws and regulations which may affect our privacy and security practices, such as state laws governing the use, disclosure and protection of social security numbers and protected health information or are designed to implement GLBA or protect credit card account data. State and local authorities increasingly focus on the importance of protecting individuals from identity theft, with a significant number of states enacting laws requiring businesses to meet minimum cyber-security standards and notify individuals of security breaches involving personal information. State consumer protection laws may also apply to privacy and security practices related to personally identifiable information, including information related to consumers and care providers. Different approaches to state privacy and insurance regulation and varying enforcement philosophies may materially and adversely affect our ability to standardize our products and services across state lines. See Part I, Item 1A, “Risk Factors” for a discussion of the risks related to compliance with state privacy and security regulations.

Corporate Practice of Medicine and Fee-Splitting Laws. Certain of our businesses function as direct medical service providers and, as such, are subject to additional laws and regulations. Some states have corporate practice of medicine laws prohibiting specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices which involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change.

Pharmacy and Pharmacy Benefits Management (PBM) Regulations

OptumRx’s businesses include home delivery, specialty and compounding pharmacies, as well as clinic-based pharmacies which must be licensed as pharmacies in the states in which they are located. Certain of our pharmacies must also register with the U.S. Drug Enforcement Administration (DEA) and individual state controlled substance authorities to dispense controlled substances. In addition to adhering to the laws and regulations in the states where our pharmacies are located, we also are required to comply with laws and regulations in some non-resident states where we deliver pharmaceuticals, including those requiring us to register with the board of pharmacy in the non-resident state. These non-resident states generally expect our pharmacies to follow the laws of the state in which the pharmacies are located, but some non-resident states also require us to

comply with their laws where pharmaceuticals are delivered. Additionally, certain of our pharmacies participate in programs for Medicare and state Medicaid providers are required to comply with applicable Medicare and Medicaid provider rules and regulations. Other laws and regulations affecting our pharmacies include federal and state statutes and regulations governing the labeling, packaging, advertising and adulteration of prescription drugs and dispensing of controlled substances. See Part I, Item 1A, "Risk Factors" for a discussion of the risks related to our pharmacy care services businesses.

Federal and state legislation of PBM activities affect both our ability to limit access to a pharmacy provider network or remove network providers. Additionally, many states limit our ability to manage and establish maximum allowable costs for generic prescription drugs. With respect to formulary services, a number of government entities, including CMS, HHS and state departments of insurance, regulate the administration of prescription drug benefits offered through federal or state exchanges. Many states also regulate the scope of prescription drug coverage, as well as the delivery channels to receive such prescriptions, for insurers, MCOs and Medicaid managed care plans. These regulations could limit or preclude (i) certain plan designs, (ii) limited networks, (iii) requirements to use particular care providers or distribution channel, (iv) copayment differentials among providers and (v) formulary tiering practices.

Legislation seeking to regulate PBM activities introduced or enacted at the federal or state level could impact our business practices with others in the pharmacy supply chain, including pharmaceutical manufacturers and network providers. Additionally, organizations like the NAIC periodically issue model regulations and credentialing organizations, like the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), may establish standards impacting PBM pharmacy activities. While these model regulations and standards do not have the force of law, they may influence states to adopt their recommendations and impact the services we deliver to our clients.

Consumer Protection Laws

Certain of our businesses participate in direct-to-consumer activities and are subject to regulations applicable to online communications and other general consumer protection laws and regulations such as the Federal Tort Claims Act, the Federal Postal Service Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws.

Certain laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission ("FCC") and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws may provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Banking Regulation

Optum Bank is subject to regulation by federal banking regulators, including the Federal Deposit Insurance Corporation, which performs annual examinations to ensure the bank is operating in accordance with federal safety and soundness requirements, and the Consumer Financial Protection Bureau, which may perform periodic examinations to ensure the bank is in compliance with applicable consumer protection statutes, regulations and agency guidelines. Optum Bank is also subject to supervision and regulation by the Utah State Department of Financial Institutions which carries out annual examinations to ensure the bank is operating in accordance with state safety and soundness requirements and performs periodic examinations of the bank's compliance with applicable state banking statutes, regulations and agency guidelines. In the event of unfavorable examination results from any of these agencies, the bank could become subject to increased operational expenses and capital requirements, enhanced governmental oversight and monetary penalties.

International Regulation

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes vary from jurisdiction to jurisdiction. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA), which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage.

COMPETITION

As a diversified health care company, we operate in highly competitive markets across the full expanse of health care benefits and services, including organizations ranging from startups to highly sophisticated Fortune 50 global enterprises, for-profit and non-profit companies, and private and government-sponsored entities. New entrants and business combinations also contribute to a dynamic and competitive environment. We compete fundamentally on the quality and value we provide to those we serve which can include elements such as product and service innovation; use of technology; consumer and provider engagement and satisfaction; sales, marketing and pricing. See Part I, Item 1A, “Risk Factors” for additional discussion of our risks related to competition.

INTELLECTUAL PROPERTY RIGHTS

We have obtained trademark registration for the UnitedHealth Group, Optum and UnitedHealthcare names and logos. We own registrations for certain of our other trademarks in the United States and abroad. We hold a portfolio of patents and have patent applications pending from time to time. We are not substantially dependent on any single patent or group of related patents.

Unless otherwise noted, trademarks appearing in this report are trademarks owned by us. We disclaim any proprietary interest in the marks and names of others.

HUMAN CAPITAL RESOURCES

Our 330,000 employees, as of December 31, 2020, including our more than 125,000 clinical professionals, are guided by our mission to help people live healthier lives and help make the health system work better for everyone. Our mission and cultural values of integrity, compassion, relationships, innovation and performance align with our long-term business strategy to increase access to care, make care more affordable, enhance the care experience and improve health outcomes. Our mission and values attract individuals who are determined to make a difference – individuals whose talent, innovation, engagement and empowerment are critical in our ability to achieve our mission.

We are committed to developing our people and culture by creating an inclusive environment where people of diverse backgrounds, experiences and perspectives make us better. Our approach is data-driven and leader led, including enterprise and business scorecards ensuring our leaders are accountable for a consistent focus on hiring, developing, advancing and retaining diverse talent. We have embedded inclusion and diversity throughout our culture, including in our talent acquisition and talent management practices; leadership development; careers; learning and skills; and systems and processes. We strive to maintain a sustainable and diverse talent pipeline by building strong strategic partnerships and outreach through early career programs, internships and apprenticeships. We support career coaching, mentorship and accelerated leadership development programs to ensure mobility and advancement for our diverse talent. To foster an engaged workforce and an inclusive culture, we invest in a broad array of learning and culture development programs. We rely on a shared leadership framework, which clearly and objectively defines our expectations, enables an environment where everyone has the opportunity to learn and grow, and helps us identify, develop and deploy talent driving us toward achieving our mission.

We prioritize pay equity by regularly evaluating and reviewing our compensation practices by gender, ethnicity and race. Receiving on-going feedback from our team members is another way we help strengthen and reinforce a culture of inclusion. Our Employee Experience Index measures an employee's sense of commitment and belonging to the Company and is a metric in the Stewardship section of our annual incentive plan. Our Sustainability Report, which can be accessed on our website at www.unitedheatlhgroup.com, provides further details on our people and culture.

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

The following sets forth certain information regarding our executive officers as of March 1, 2021, including the business experience of each executive officer during the past five years:

Name	Age	Position
Andrew P. Witty	56	Chief Executive Officer; Chief Executive Officer of Optum
Dirk C. McMahon	61	President and Chief Operating Officer; Chief Executive Officer of UnitedHealthcare
John F. Rex	59	Executive Vice President; Chief Financial Officer
Thomas E. Roos	48	Senior Vice President; Chief Accounting Officer
Patricia L. Lewis	58	Executive Vice President; Chief Human Resources Officer

Our Board of Directors elects executive officers annually. Our executive officers serve until their successors are duly elected and qualified, or until their earlier death, resignation, removal or disqualification.

Mr. Witty is Chief Executive Officer and a member of the Board of Directors of UnitedHealth Group and has served in these roles since February 2021. In addition, Mr. Witty is Chief Executive Officer of Optum and has served in this capacity since July 2018. Mr. Witty previously served as President of UnitedHealth Group from November 2019 to February 2021 and as a UnitedHealth Group director from August 2017 to March 2018. From April 2020 to November 2020, Mr. Witty took an unpaid leave of absence from his positions at UnitedHealth Group and Optum to serve as a Global Envoy for the World Health Organization's COVID-19 efforts. Prior to joining UnitedHealth Group, he was Chief Executive Officer and a board member of GlaxoSmithKline, a global pharmaceutical company, from 2008 to April 2017.

Mr. McMahon is President and Chief Operating Officer of UnitedHealth Group and has served in this capacity since February 2021. In addition, Mr. McMahon is Chief Executive Officer of UnitedHealthcare and has served in this capacity since June 2019. Mr. McMahon previously served as President and Chief Operating Officer of Optum from April 2017 to June 2019 and as Executive Vice President, Operations at UnitedHealth Group from November 2014 to April 2017. Mr. McMahon also served as Chief Executive Officer of OptumRx from November 2011 to November 2014. Prior to 2011, he held various positions in UnitedHealthcare in operations, technology and finance.

Mr. Rex is Executive Vice President and Chief Financial Officer of UnitedHealth Group and has served in this capacity since June 2016. From March 2012 to June 2016, Mr. Rex served as Executive Vice President and Chief Financial Officer of Optum. Prior to joining Optum in 2012, Mr. Rex was a Managing Director at JP Morgan, a global financial services firm.

Mr. Roos is Senior Vice President and Chief Accounting Officer of UnitedHealth Group and has served in this capacity since August 2015. Prior to joining UnitedHealth Group, Mr. Roos was a Partner at Deloitte & Touche LLP, an independent registered public accounting firm, from September 2007 to August 2015.

Ms. Lewis is Executive Vice President and Chief Human Resources Officer of UnitedHealth Group and has served in this capacity since October 2019. Prior to joining UnitedHealth Group, Ms. Lewis served at Lockheed

Martin where she was Senior Vice President and Chief Human Resources Officer from December 2014 to October 2019. Prior to joining Lockheed Martin Corporation, a global security and aerospace company, in 2011, Ms. Lewis held various positions in Human Resources at International Business Machines Corporation, a global technology company, and DuPont De Nemours, Inc, a global diversified chemicals company. Ms. Lewis currently serves as a director of Lear, Inc.

Additional Information

Our executive offices are located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343; our telephone number is (952) 936-1300.

You can access our website at www.unitedhealthgroup.com to learn more about our company. From the site you can download and print copies of our annual reports to shareholders, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, along with amendments to those reports. You can also download from our website our certificate of incorporation and bylaws; corporate governance policies, including our Principles of Governance; Board of Directors Committee Charters; Code of Conduct; and annual sustainability report. We make periodic reports and amendments available, free of charge, on our website, as soon as reasonably practicable after we file or furnish these reports to the Securities and Exchange Commission (SEC). We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: UnitedHealth Group Incorporated, 9900 Bren Road East, Minnetonka, MN 55343, Attn: Corporate Secretary. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Our transfer agent, Equiniti (EQ), can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: EQ Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, or telephone (800) 401-1957 or (651) 450-4064.

ITEM 1A. RISK FACTORS

CAUTIONARY STATEMENTS

The statements, estimates, projections or outlook contained in this Annual Report on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the SEC, in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words “believe,” “expect,” “intend,” “estimate,” “anticipate,” “forecast,” “outlook,” “plan,” “project,” “should” or similar words or phrases are intended to identify such forward-looking statements. These statements are intended to take advantage of the “safe harbor” provisions of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. Any forward-looking statement in this report speaks only as of the date of this report and, except as required by law, we undertake no obligation to update any forward-looking statement to reflect events or circumstances, including unanticipated events, after the date of this report.

The following discussion contains cautionary statements regarding our business, which investors and others should consider. We do not undertake to address in future filings or communications regarding our business or results of operations how any of these factors may have caused our results to differ from discussions or information contained in previous filings or communications. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results. Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make

may turn out to be wrong. Our forward-looking statements can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many factors discussed below will be important in determining our future results. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions which are difficult to predict or quantify.

Risks Related to Our Business and Our Industry

We are subject to risks associated with public health crises, large-scale medical emergencies and pandemics, such as the COVID-19 pandemic, which could have a material adverse effect on our business, results of operations, financial condition and financial performance.

The ongoing COVID-19 global health crisis continues to have major impacts on health systems, businesses, governments and customer and consumer activities. We have mobilized the full strength of our resources to deliver the best care for patients, support for our members and care provider partners, keep our employees safe and deliver innovative solutions and support for the communities we serve and the entire health system. The impact to our business is primarily dependent upon the ultimate pacing, intensity and duration of the crisis, and the timing for widespread availability and effectiveness of a vaccine, factors which remain uncertain at this time. These factors continue to affect the related treatment, testing, coverage and other services we provide for the people we serve. As the crisis abates, we may experience an increase in medical care costs as people seek care which was deferred during the pandemic and individuals with chronic conditions may require additional care needs resulting from missed treatments. The premiums and fees we charge, including premiums dependent upon documented health conditions, may not be sufficient to cover the medical and administrative costs associated with COVID-19 and other care services. In addition, we have experienced and may continue to experience reduced demand for certain services Optum provides to care providers, health plans and employers as a result of reduced clinical and claims activity and changes in business priorities resulting from COVID-19.

The COVID-19 pandemic has resulted in our customers having to close or severely curtail their operations. Among other impacts, we have experienced and may continue to experience loss of commercial and pharmacy care services members due to customer reductions in workforce and an adverse impact on the timing and collectability of premium payments. In addition, governments have modified, and may continue to modify, regulatory standards around various aspects of health care in response to COVID-19, and these changing standards may create challenges for us to ensure timely compliance and meet various contractual obligations.

Further disruptions in public and private infrastructure, including supply chains providing medical supplies and pharmaceutical products, could adversely disrupt our business operations or increase our operating costs. Additionally, the enactment of emergency powers by governments could disrupt our business operations, including restricting pharmaceuticals or other supplies, and could increase the risk of shortages of necessary items.

Although we cannot predict the pacing, intensity and duration of COVID-19, the pandemic's disruption to business activities, employment and economic effects, and near and long-term impacts on the patterns of care and services across the healthcare system could continue to have material and adverse effects on our business, results of operations, financial position or cash flows.

If we fail to estimate, price for and manage our medical costs in an effective manner, the profitability of our risk-based products and services could decline and could materially and adversely affect our results of operations, financial position and cash flows.

Through our risk-based benefit products, we assume the risk of both medical and administrative costs for our customers in return for monthly premiums. We generally use approximately 80% to 85% of our premium revenues to pay the costs of health care services delivered to these customers. The profitability of our products

depends in large part on our ability to predict, price for and effectively manage medical costs. Our OptumHealth business negotiates risk-based arrangements with commercial third-party payers which are also included in premium revenues. Under a typical arrangement, OptumHealth receives a fixed percentage of a third-party payer's premiums to cover all or a defined portion of the medical costs provided to members. Premium revenues from risk-based products comprise nearly 80% of our total consolidated revenues. If we fail to predict accurately, or effectively price for or manage, the costs of providing care under risk-based arrangements, our results of operations could be materially and adversely affected.

We manage medical costs through underwriting criteria, product design, negotiation of competitive provider contracts and care management programs. Total medical costs are affected by the number of individual services rendered, the cost of each service and the type of service rendered. Our premium revenue on commercial policies and Medicaid contracts is typically based on a fixed monthly rate per individual served for a 12-month period and is generally priced one to six months before the contract commences. Our revenue on Medicare policies is based on bids submitted to CMS in June the year before the contract year. Although we base the commercial and Medicaid premiums we charge and our Medicare bids on our estimates of future medical costs over the fixed contract period, many factors may cause actual costs to exceed those estimated and reflected in premiums or bids. These factors may include medical cost inflation, increased use of services, increased cost of individual services, large-scale medical emergencies, pandemics, such as COVID-19, the introduction of new or costly drugs, treatments and technology, new treatment guidelines, new mandated benefits (such as the expansion of essential benefits coverage) or other regulatory changes and insured population characteristics. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenues can result in significant changes in our financial results. For example, if our 2020 medical costs for commercial insured products had been 1% higher than our actual medical costs, without proportionally higher revenues from such products, our annual net earnings for 2020 would have been reduced by approximately $290 million, excluding any offsetting impact from risk adjustment or from reduced premium rebates due to minimum MLRs.

In addition, the financial results we report for any particular period include estimates of costs incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. If these estimates prove inaccurate, our results of operations could be materially and adversely affected.

If we fail to maintain properly the integrity or availability of our data or successfully consolidate, integrate, upgrade or expand our existing information systems, or if our technology products do not operate as intended, our business could be materially and adversely affected.

Our business is highly dependent on the integrity and timeliness of the data we use to serve our members, customers and health care professionals and to operate our business. The volume of health care data generated, and the uses of data, including electronic health records, are rapidly expanding. Our ability to implement new and innovative services, price adequately our products and services, provide effective service to our customers in an efficient and uninterrupted fashion, and report accurately our results of operations depends on the integrity of the data in our information systems. In addition, connectivity among technologies is becoming increasingly important and recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. If the data we rely upon to run our businesses is found to be inaccurate or unreliable or if we fail to maintain or protect our information systems and data integrity effectively, we could experience failures in our health, wellness and information technology products; lose existing customers; have difficulty attracting new customers; experience problems in determining medical cost estimates and establishing appropriate pricing; have difficulty preventing, detecting and controlling fraud; have disputes with customers, physicians and other health care professionals; become subject to regulatory sanctions or penalties; incur increases in operating expenses or suffer other adverse consequences.

We periodically consolidate, integrate, upgrade and expand our information systems' capabilities as a result of technology initiatives and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. Our process of consolidating the number of systems we operate, upgrading and expanding our information systems' capabilities, enhancing our systems and developing new systems to keep pace with continuing changes in information processing technology may not be successful. Failure to protect, consolidate and integrate our systems successfully could result in higher than expected costs and diversion of management's time and energy, which could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses sell and install software products which may contain unexpected design defects or may encounter unexpected complications during installation or when used with other technologies utilized by the customer. A failure of our technology products to operate as intended and in a seamless fashion with other products could materially and adversely affect our results of operations, financial position and cash flows.

Uncertain and rapidly evolving U.S. federal and state, non-U.S. and international laws and regulations related to health data and the health information technology market may alter the competitive landscape or present compliance challenges and could materially and adversely affect the configuration of our information systems and platforms, and our ability to compete in this market.

If we sustain cyber-attacks or other privacy or data security incidents resulting in security breaches disrupting our operations or resulting in the unintended dissemination of protected personal information or proprietary or confidential information, we could suffer a loss of revenue and increased costs, exposure to significant liability, reputational harm and other serious negative consequences.

We routinely process, store and transmit large amounts of data in our operations, including protected personal information subject to privacy, security or data breach notification laws, as well as proprietary or confidential information relating to our business or third parties. Some of the data we process, store and transmit may be outside of the United States due to our information technology systems and international business operations. We are regularly the target of attempted cyber-attacks and other security threats and may be subject to breaches of the information technology systems we use. We have programs in place which are intended to detect, contain and respond to data security incidents and provide employee awareness training regarding phishing, malware and other cyber risks to protect against cyber risks and security breaches. However, because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and are increasing in sophistication, we may be unable to anticipate these techniques, detect breaches for long periods of time or implement adequate preventive measures. Experienced computer programmers and hackers may be able to penetrate our security controls and access, misappropriate or otherwise compromise protected personal information or proprietary or confidential information or that of third parties, create system disruptions or cause system shutdowns, negatively affecting our operations. They also may be able to develop and deploy viruses, worms and other malicious software programs attacking our systems or otherwise exploit any security vulnerabilities. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems which could unexpectedly compromise information security. In addition, we are subject to heightened vulnerability to cybersecurity attacks associated with increased numbers of employees working from home. Our facilities and services may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; coordinated attacks by activist entities; financial fraud schemes; misplaced or lost data; human error; malicious social engineering; or other events which could negatively affect our systems, our customers' data, proprietary or confidential information relating to our business or third parties, or our operations. In certain circumstances we may rely on third-party vendors to process, store and transmit large amounts of data for our business whose operations are subject to similar risks.

The costs to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be material. Our remediation efforts may not be successful and could result in interruptions, delays, or

cessation of service and loss of existing or potential customers. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information, proprietary information or confidential information about us or our customers or other third parties, could expose our customers' private information and our customers to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and liability, including regulatory penalties, for us, damage our brand and reputation, or otherwise harm our business.

If we fail to compete effectively to maintain or increase our market share, including maintaining or increasing enrollments in businesses providing health benefits, our results of operations, financial position and cash flows could be materially and adversely affected.

Our businesses compete throughout the United States, South America and other foreign markets and face significant competition in all of the geographic markets in which we operate. In particular geographies or segments, our competitors, compared to us, may have greater capabilities, resources or market share; a more established reputation; superior supplier or health care professional arrangements; better existing business relationships; lower profit margin or financial return expectations; or other factors which give such competitors a competitive advantage. Our competitive position may also be adversely affected by significant merger and acquisition activity in the industries in which we operate, both among our competitors and suppliers. Consolidation may make it more difficult for us to retain or increase our customer base, improve the terms on which we do business with our suppliers, or maintain or increase profitability.

In addition, our success in the health care marketplace will depend on our ability to develop and deliver innovative and potentially disruptive products and services to satisfy evolving market demands. If we do not continue to innovate and provide products and services, which are useful and relevant to consumers and our customers, we may not remain competitive, and we risk losing market share to existing competitors and disruptive new market entrants. For example, new direct-to-consumer business models from competing businesses may make it more difficult for us to directly engage consumers in the selection and management of their health care benefits and health care usage. We may face challenges from new technologies and market entrants which could affect our existing relationship with health plan enrollees in these areas. Any failure by us to continue to develop innovative care models could result in competitive disadvantages and loss of market share. Our business, results of operations, financial position and cash flows could be materially and adversely affected if we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets, if we do not design and price our products properly and competitively, if we are unable to innovate and deliver products and services demonstrating value to our customers, if we do not provide a satisfactory level of services, if membership or demand for other services does not increase as we expect or declines, or if we lose accounts with more profitable products while retaining or increasing membership in accounts with less profitable products.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other service providers, our business could be materially and adversely affected.

Our results of operations and prospects are substantially dependent on our continued ability to contract with physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and other service providers at competitive prices. Any failure by us to develop and maintain satisfactory relationships with health care providers, whether in-network or out-of-network, could materially and adversely affect our business, results of operations, financial position and cash flows. In addition, certain activities related to network design, provider participation in networks and provider payments could result in disputes, which may be costly, divert management's attention from our operations and result in negative publicity.

In any particular market, physicians and health care providers could refuse to contract, demand higher payments, or take other actions which could result in higher medical costs, less desirable products for customers or difficulty meeting regulatory or accreditation requirements. In some markets, certain health care providers, particularly hospitals, physician and hospital organizations or multi-specialty physician groups, may have

significant market positions or near monopolies which could result in diminished bargaining power on our part. In addition, ACOs; practice management companies (which aggregate physician practices for administrative efficiency); and other organizational structures adopted by physicians, hospitals and other care providers may change the way in which these providers do business with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which could adversely affect our business, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way we price our products and estimate our costs, which might require us to incur costs to change our operations. In addition, if these providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

Our health care benefits businesses have risk-based arrangements with some physicians, hospitals and other health care providers. These arrangements limit our exposure to the risk of increasing medical costs, but expose us to risk related to the adequacy of the financial and medical care resources of the health care provider. To the extent a risk-based health care provider organization faces financial difficulties or otherwise is unable to perform its obligations under the arrangement, we may be held responsible for unpaid health care claims which should have been the responsibility of the health care provider and for which we have already paid the provider. Further, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts could result in a disruption in the provision of services to our members or a reduction in the services available to our members. Health care providers with which we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

Some providers render services to our members who do not have contracts with us. In those cases, we do not have a pre-established understanding about the amount of compensation due to the provider for services rendered to our members. In some states, the amount of compensation due to these out-of-network providers is defined by law or regulation, but in most instances the amount is either not defined or is established by a standard which does not clearly specify dollar terms. In some instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover from our members the difference between what we have paid them and the amount they charged us.

The success of some of our businesses, including OptumHealth and UnitedHealthcare Global, depend on maintaining satisfactory relationships with physicians as our employees, independent contractors or joint venture partners. The physicians who practice medicine or contract with our affiliated physician organizations could terminate their provider contracts or otherwise become unable or unwilling to continue practicing medicine or contracting with us. We face and will likely continue to face heightened competition in the markets where we operate to acquire or manage physician practices or to employ or contract with individual physicians. If we are unable to maintain or grow satisfactory relationships with physicians, or to acquire, recruit or, in some instances, employ physicians, or to retain enrollees following the departure of a physician, our revenues could be materially and adversely affected. In addition, our affiliated physician organizations contract with competitors of UnitedHealthcare. Our businesses could suffer if our affiliated physician organizations fail to maintain relationships with these companies, or fail to adequately price their contracts with these third-party payers.

In addition, physicians, hospitals, pharmaceutical benefit service providers, pharmaceutical manufacturers and certain health care providers are customers of our Optum businesses. Physicians also provide medical services at facilities owned by our Optum businesses. Given the importance of health care providers and other constituents to our businesses, failure to maintain satisfactory relationships with them could materially and adversely affect our results of operations, financial position and cash flows.

We are routinely subject to various legal actions due to the nature of our business, which could damage our reputation and, if resolved unfavorably, could result in substantial penalties or monetary damages and materially and adversely affect our results of operations, financial position and cash flows.

We are routinely made party to a variety of legal actions related to, among other matters, the design, management and delivery of our product and service offerings. These matters have included or could in the future include matters related to health care benefits coverage and payment claims (including disputes with enrollees, customers and contracted and non-contracted physicians, hospitals and other health care professionals), tort claims (including claims related to the delivery of health care services, such as medical malpractice by staff at our affiliates' facilities, or by health care practitioners who are employed by us, have contractual relationships with us, or serve as providers to our managed care networks), whistleblower claims (including claims under the False Claims Act or similar statutes), contract and labor disputes, tax claims and claims related to disclosure of certain business practices. We may also be party to certain class action lawsuits brought by health care professional groups and consumers. In addition, we operate in jurisdictions outside of the United States where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and therefore subject to dispute by customers, government authorities or others. We are largely self-insured with regard to litigation risks. While we maintain excess liability insurance with outside insurance carriers for claims in excess of our self-insurance, certain types of damages, such as punitive damages in some circumstances, are not covered by insurance. Although we record liabilities for our estimates of the probable costs resulting from self-insured matters, it is possible the level of actual losses will significantly exceed the liabilities recorded.

We cannot predict the outcome of significant legal actions in which we are involved and are incurring expenses in resolving these matters. The legal actions we face or may face in the future could further increase our cost of doing business and materially and adversely affect our results of operations, financial position and cash flows. In addition, certain legal actions could result in adverse publicity which could damage our reputation and materially and adversely affect our ability to retain our current business or grow our market share in some markets and businesses.

Any failure by us to manage successfully our strategic alliances or complete, manage or integrate acquisitions and other significant strategic transactions or relationships domestically or outside the United States could materially and adversely affect our business, prospects, results of operations, financial position and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures and outsourcing transactions and often enter into agreements relating to such transactions. For example, we have a strategic alliance with AARP under which we provide AARP-branded Medicare Supplement insurance to AARP members and other AARP-branded products and services to Medicare beneficiaries. If we fail to meet the needs of our alliance or joint venture partners, including by developing additional products and services, providing high levels of service, pricing our products and services competitively or responding effectively to applicable federal and state regulatory changes, our alliances and joint ventures could be damaged or terminated which in turn could adversely impact our reputation, business and results of operations. Further, if we fail to identify and successfully complete transactions, which further our strategic objectives, we may be required to expend resources to develop products and technology internally, we may be placed at a competitive disadvantage or we may be adversely affected by negative market perceptions, any of which may have a material adverse effect on our results of operations, financial position or cash flows.

Success in completing acquisitions is also dependent on effectively integrating the acquired business into our existing operations, including our internal control environment and culture, or otherwise leveraging its operations which may present challenges different from those presented by organic growth and may be difficult for us to manage. In addition, even with appropriate diligence, pre-acquisition practices of an acquired business may

expose us to legal challenges and investigations. For example, in January 2021, an indictment for alleged violations of antitrust laws was issued by the DOJ against our subsidiary, Surgical Care Affiliates (SCA), based on conduct alleged to have begun more than five years prior to our acquisition. We are vigorously defending this lawsuit, but if SCA is found liable, we may be subject to criminal fines or reputational harm. If we cannot successfully integrate these acquisitions and realize contemplated revenue growth opportunities and cost savings, our business, prospects, results of operations, financial position and cash flows could be materially and adversely affected.

As we expand and operate our business outside of the United States, we are presented with challenges differing from those presented by acquisitions of domestic businesses, including challenges in adapting to new markets, languages, business, labor and cultural practices and regulatory environments. Adapting to these challenges could require us to devote significant senior management attention and other resources to the acquired businesses before we realize anticipated synergies or other benefits from the acquired businesses. These challenges vary widely by country and, outside of the United States, may include political instability, government intervention, discriminatory regulation and currency exchange controls or other restrictions, which could prevent us from transferring funds from these operations out of the countries in which our acquired businesses operate, or converting local currencies we hold into U.S. dollars or other currencies. If we are unable to manage successfully our non-U.S. acquisitions, our business, prospects, results of operations and financial position could be materially and adversely affected.

Foreign currency exchange rates and fluctuations may have an impact on our shareholders' equity from period to period, which could adversely affect our debt to debt-plus-equity ratio, and our future revenues, costs and cash flows from international operations. Any measures we may implement to reduce the effect of volatile currencies may be costly or ineffective.

Our sales performance will suffer if we do not adequately attract, retain and provide support to a network of independent producers and consultants.

Our products and services are sold in part through nonexclusive producers and consultants for whose services and allegiance we must compete. Our sales would be materially and adversely affected if we are unable to attract, retain and support such independent producers and consultants or if our sales strategy is not appropriately aligned across distribution channels. Our relationships with producers could be materially and adversely impacted by changes in our business practices and the nature of our relationships to address these pressures, including potential reductions in commission levels.

Unfavorable economic conditions could materially and adversely affect our revenues and our results of operations.

Unfavorable economic conditions may impact demand for certain of our products and services. For example, high unemployment has caused lower enrollment or lower rates of renewal in our employer group benefits and pharmacy services plans. Unfavorable economic conditions also have caused and could continue to cause employers to stop offering certain health care coverage as an employee benefit or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs. In addition, unfavorable economic conditions could adversely impact our ability to increase premiums or result in the cancellation by certain customers of our products and services. These conditions could lead to a decrease in our membership levels and premium and fee revenues and could materially and adversely affect our results of operations, financial position and cash flows.

During a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced reimbursements or payments in our federal and state government health care coverage programs, including Medicare, Medicaid and CHIP. A reduction in state Medicaid reimbursement rates could be implemented retroactively to apply to payments already negotiated or received from the

government and could materially and adversely affect our results of operations, financial position and cash flows. In addition, state and federal budgetary pressures could cause the affected governments to impose new or a higher level of taxes or assessments for our commercial programs, such as premium taxes on health insurance and surcharges or fees on select fee-for-service and capitated medical claims. Any of these developments or actions could materially and adversely affect our results of operations, financial position and cash flows.

A prolonged unfavorable economic environment also could adversely impact the financial position of hospitals and other care providers which could materially and adversely affect our contracted rates with these parties and increase our medical costs or materially and adversely affect their ability to purchase our service offerings. Further, unfavorable economic conditions could adversely impact the customers of our Optum businesses, including health plans, hospitals, care providers, employers and others which could, in turn, materially and adversely affect Optum's financial results.

Our failure to attract, develop, retain, and manage the succession of key employees and executives could adversely affect our business, results of operations and future performance.

We are dependent on our ability to attract, develop and retain qualified employees and executives, including those with diverse backgrounds, experiences and skill sets, to operate and expand our business. Experienced and highly skilled employees and executives in the health care and technology industries are in high demand and the market for their services is extremely competitive. We may have difficulty in replacing key executives because of the limited number of qualified individuals in these industries with the breadth of skills and experience required to operate and successfully expand our business. In addition, we believe our corporate culture fosters integrity, compassion, relationships, innovation and performance. Adverse changes to our corporate culture could harm our business operations and our ability to retain key employees and executives. While we have development and succession plans in place for our key employees and executives, these plans do not guarantee the services of our key employees and executives will continue to be available to us. If we are unable to attract, develop, retain and effectively manage the development and succession plans for key employees and executives, our business, results of operations and future performance could be adversely affected.

Our investment portfolio may suffer losses which could adversely affect our results of operations, financial position and cash flows.

Market fluctuations could impair our profitability and capital position. Volatility in interest rates affects our interest income and the market value of our investments in debt securities of varying maturities which constitute the vast majority of the fair value of our investments as of December 31, 2020. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted our investment income. In addition, a delay in payment of principal or interest by issuers, or defaults by issuers (primarily issuers of our investments in corporate and municipal bonds), could reduce our investment income and require us to write down the value of our investments which could adversely affect our profitability and equity.

There can be no assurance our investments will produce total positive returns or we will not sell investments at prices which are less than their carrying values. Changes in the value of our investment assets, as a result of interest rate fluctuations, changes in issuer financial conditions, illiquidity or otherwise, could have an adverse effect on our equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, such an action could have an adverse effect on our results of operations and the capital position of our regulated subsidiaries.

If the value of our intangible assets is materially impaired, our results of operations, equity and credit ratings could be materially and adversely affected.

As of December 31, 2020, our goodwill and other intangible assets had a carrying value of $82 billion, representing 42% of our total consolidated assets. We periodically evaluate our goodwill and other intangible

assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. The value of our goodwill may be materially and adversely impacted if businesses we acquire perform in a manner inconsistent with our assumptions. In addition, from time to time we divest businesses, and any such divestiture could result in significant asset impairment and disposition charges, including those related to goodwill and other intangible assets. Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially and adversely affect our results of operations and equity in the period in which the impairment occurs. A material decrease in equity could, in turn, adversely affect our credit ratings.

If we are not able to protect our proprietary rights to our databases, software and related products, our ability to market our knowledge and information-related businesses could be hindered and our results of operations, financial position and cash flows could be materially and adversely affected.

We rely on our agreements with customers, confidentiality agreements with employees and third parties, and our trademarks, trade secrets, copyrights and patents to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, and we expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this industry segment grows. Such litigation and misappropriation of our proprietary information could hinder our ability to market and sell products and services and our results of operations, financial position and cash flows could be materially and adversely affected.

Any downgrades in our credit ratings could adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength and debt ratings by Nationally Recognized Statistical Rating Organizations are important factors in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used by customers and creditors. We believe our claims paying ability and financial strength ratings are important factors in marketing our products to certain of our customers. Our credit ratings impact both the cost and availability of future borrowings. Each of the credit rating agencies reviews its ratings periodically. Our ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to policyholders. There can be no assurance our current credit ratings will be maintained in the future. Any downgrades in our credit ratings could materially increase our costs of or ability to access funds in the debt capital markets and otherwise materially increase our operating costs.

Risks Related to the Regulation of Our Business

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could materially and adversely affect our business.

We are regulated by federal, state and local governments in the United States and other countries where we do business. Our insurance and HMO subsidiaries must be licensed by and are subject to regulation in the jurisdictions in which they conduct business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations and some of our activities may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs, UR and TPA-related regulations and licensure requirements. 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 who write the same line or similar lines of business. Any such assessment could expose our insurance entities and other insurers to the risk they would be required to pay a portion of an impaired or insolvent insurance company's claims through state guaranty associations.

Certain of our businesses provide products or services to various government agencies. For example, some of our Optum and UnitedHealthcare businesses hold government contracts or provide services related to government contracts and are subject to U.S. federal and state and non U.S. self-referral, anti-kickback, medical necessity, risk adjustment, false claims and other laws and regulations governing government contractors and the use of government funds. Our relationships with these government agencies are subject to the terms of contracts we hold with the agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies which might be viewed as an actual or potential conflict of interest. These laws may limit our ability to pursue and perform certain types of work, thereby materially and adversely affecting our results of operations, financial position and cash flows.

Certain of our Optum businesses are also subject to regulations distinct from those faced by our insurance and HMO subsidiaries, some of which could impact our relationships with physicians, hospitals and customers. These regulations include state telemedicine regulations; debt collection laws; banking regulations; distributor and producer licensing requirements; state corporate practice of medicine doctrines; fee-splitting rules; and health care facility licensure and certificate of need requirements. These risks and uncertainties may materially and adversely affect our ability to market or provide our products and services, or to do so at targeted operating margins, or may increase the regulatory burdens under which we operate.

The laws and rules governing our businesses and interpretations of those laws and rules are subject to frequent change. For example, legislative, administrative and public policy changes to the ACA are being considered, and we cannot predict if the ACA will be further modified. Litigation challenges have been brought seeking to invalidate the ACA in whole or in part. A federal appeals court struck down the ACA as in part unconstitutional in 2019. During the fourth quarter of 2020, the Supreme Court heard oral arguments in the case. Further, the integration into our businesses of entities we acquire may affect the way in which existing laws and rules apply to us, including by subjecting us to laws and rules which did not previously apply to us. The broad latitude given to the agencies administering, interpreting and enforcing current and future regulations governing our businesses could force us to change how we do business, restrict revenue and enrollment growth, increase our health care and administrative costs and capital requirements, or expose us to increased liability in courts for coverage determinations, contract interpretation and other actions.

We also must obtain and maintain regulatory approvals to market many of our products and services, increase prices for certain regulated products and services and complete certain acquisitions and dispositions or integrate certain acquisitions. For example, premium rates for our health insurance and managed care products are subject to regulatory review or approval in many states and by the federal government. Additionally, we must submit data on all proposed rate increases on many of our products to HHS for monitoring purposes. Geographic and product expansions of our businesses may be subject to state and federal regulatory approvals. Delays in obtaining necessary approvals or our failure to obtain or maintain adequate approvals could materially and adversely affect our results of operations, financial position and cash flows.

Certain of our businesses operate internationally and are subject to regulation in the jurisdictions in which they are organized or conduct business. These regulatory regimes encompass, among other matters, local and cross-border taxation, licensing, tariffs, intellectual property, investment, capital (including minimum solvency margin and reserve requirements), management control, labor, anti-fraud, anti-corruption and privacy and data protection regulations (including requirements for cross-border data transfers) which vary by jurisdiction. We currently operate outside of the United States and in the future may acquire or commence additional businesses based outside of the United States, increasing our exposure to non-U.S. regulatory regimes. For example, our UnitedHealthcare Global business subjects us to Brazilian laws and regulations affecting hospitals, managed care and insurance industries and to regulation by Brazilian regulators, including the national regulatory agency for private health insurance and plans, the Agência Nacional de Saúde Suplementar, while our Banmédica business is subject to Chilean, Colombian and Peruvian laws, regulations and regulators applicable to hospitals and private insurance. Any international regulator may take an approach to the interpretation, implementation and

enforcement of industry regulations which could differ from the approach taken by U.S. regulators. In addition, our non-U.S. businesses and operations are subject to U.S. laws regulating the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA, which prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. Our failure to comply with U.S. or non-U.S. laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could adversely affect our ability to market our products and services, or to do so at targeted operating margins which may have a material adverse effect on our business, financial condition and results of operations.

The health care industry is regularly subject to negative publicity, including as a result of governmental investigations, adverse media coverage and political debate surrounding industry regulation. Negative publicity may adversely affect our stock price and damage our reputation in various markets.

As a result of our participation in various government health care programs, both as a payer and as a service provider to payers, we are exposed to additional risks associated with program funding, enrollments, payment adjustments, audits and government investigations which could materially and adversely affect our business, results of operations, financial position and cash flows.

We participate in various federal, state and local government health care benefit programs, including as a payer in Medicare Advantage, Medicare Part D, various Medicaid programs and CHIP, and receive substantial revenues from these programs. Certain of our Optum businesses also provide services to payers participating in government health care programs. A reduction or less than expected increase, or a protracted delay, in government funding for these programs or change in allocation methodologies, or termination of the contract at the option of the government, may materially and adversely affect our results of operations, financial position and cash flows.

The government health care programs in which we participate generally are subject to frequent changes, including changes which may reduce the number of persons enrolled or eligible for coverage, reduce the amount of reimbursement or payment levels, reduce our participation in certain service areas or markets, or increase our administrative or medical costs under such programs. Revenues for these programs depend on periodic funding from the federal government or applicable state governments and allocation of the funding through various payment mechanisms. Funding for these government programs depends on many factors outside of our control, including general economic conditions and budgetary constraints at the federal or applicable state level. For example, CMS has in the past reduced or frozen Medicare Advantage benchmarks, and additional cuts to Medicare Advantage benchmarks are possible. In addition, from time to time, CMS makes changes to the way it calculates Medicare Advantage risk adjustment payments. Although we have adjusted members' benefits and premiums on a selective basis, ceased to offer benefit plans in certain counties, and intensified both our medical and operating cost management in response to the benchmark reductions and other funding pressures, these or other strategies may not fully address the funding pressures in the Medicare Advantage program. In addition, payers in the Medicare Advantage program may be subject to reductions in payments from CMS as a result of decreased funding or recoupment pursuant to government audit.

Under the Medicaid managed care program, state Medicaid agencies seek bids from eligible health plans to continue their participation in the acute care Medicaid health programs. If we are not successful in obtaining renewals of state Medicaid managed care contracts, we risk losing the members who were enrolled in those Medicaid plans. Under the Medicare Part D program, to qualify for automatic enrollment of low income members, our bids must result in an enrollee premium below a regional benchmark, which is calculated by the government after all regional bids are submitted. If the enrollee premium is not below the government benchmark, we risk losing the members who were auto-assigned to us and will not have additional members auto-assigned to us. In general, our bids are based upon certain assumptions regarding enrollment, utilization, medical costs and other factors. If any of these assumptions is materially incorrect, either as a result of unforeseen changes to the programs on which we bid, implementation of material program or policy changes

after our bid submission, or submission by our competitors at lower rates than our bids, our results of operations, financial position and cash flows could be materially and adversely affected.

Many of the government health care coverage programs in which we participate are subject to the prior satisfaction of certain conditions or performance standards or benchmarks. For example, as part of the ACA, CMS has a system providing various quality bonus payments to Medicare Advantage plans meeting certain quality star ratings at the individual plan or local contract level. The star rating system considers various measures adopted by CMS, including, among others, quality of care, preventive services, chronic illness management, handling of appeals and customer satisfaction. Plans must have a rating of four stars or higher to qualify for bonus payments. If we do not maintain or continue to improve our star ratings, our plans may not be eligible for quality bonuses and we may experience a negative impact on our revenues and the benefits our plans can offer, which could materially and adversely affect the marketability of our plans, our membership levels, results of operations, financial position and cash flows. Any changes in standards or care delivery models applying to government health care programs, including Medicare and Medicaid, or our inability to improve our quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs, which in turn could materially and adversely affect our results of operations, financial position and cash flows.

CMS uses various payment mechanisms to allocate funding for Medicare programs, including adjustment of monthly 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 for Medicare Advantage plans, as well as, for Medicare Part D plans, risk-sharing provisions based on a comparison of costs predicted in our annual bids to actual prescription drug costs. Some state Medicaid programs utilize a similar process. For example, our UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State businesses submit information relating to the health status of enrollees to CMS or state agencies for purposes of determining the amount of certain payments to us. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation (RADV) audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Certain of our local plans have been selected for such audits, which in the past have resulted and in the future could result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS.

We have been and may in the future become involved in routine, regular and special governmental investigations, audits, reviews and assessments. Such investigations, audits, reviews or assessments sometimes arise out of, or prompt claims by private litigants or whistleblowers who, among other allegations, we failed to disclose certain business practices or, as a government contractor, submitted false or erroneous claims to the government. Governmental investigations, audits, reviews and assessments could lead to government actions, which have resulted in, and in the future could result in, adverse publicity, the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs, any of which could have a material adverse effect on our business, results of operations, financial position and cash flows.

Our businesses providing pharmacy care services face regulatory and operational risks and uncertainties which may differ from the risks of our other businesses.

We provide pharmacy care services through our OptumRx and UnitedHealthcare businesses. Each business is subject to federal and state anti-kickback, beneficiary inducement and other laws governing the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. In addition, federal and state legislatures regularly consider new regulations for the industry which could materially affect current industry practices, including potential new legislation and regulations regarding the receipt or disclosure of rebates and other fees from pharmaceutical companies, the development and use of formularies and other utilization management tools, the use of average wholesale prices or other pricing benchmarks, pricing for

specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies. Additionally, various governmental agencies have conducted investigations into certain PBM practices, which have resulted in other PBMs agreeing to civil penalties, including the payment of money and entry into corporate integrity agreements. As a provider of pharmacy benefit management services, OptumRx is also subject to an increasing number of licensure, registration and other laws and accreditation standards impacting the business practices of a pharmacy benefit manager. OptumRx also conducts business through home delivery, specialty and compounding pharmacies, pharmacies located in community mental health centers and home infusion, which subjects it to extensive federal, state and local laws and regulations, including those of the DEA and individual state controlled substance authorities, the Food and Drug Administration (FDA) and Boards of Pharmacy.

We could face potential claims in connection with purported errors by our home delivery, specialty or compounding or clinic-based pharmacies or the provision of home infusion services, including as a result of the risks inherent in the packaging and distribution of pharmaceuticals and other health care products. Disruptions from any of our home delivery, specialty pharmacy or home infusion services could materially and adversely affect our results of operations, financial position and cash flows.

In addition, our pharmacy care services businesses provide services to sponsors of health benefit plans subject to ERISA. A private party or the DOL, which is the agency who enforces ERISA, could assert the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy care services businesses even where those businesses are not contractually obligated to assume fiduciary obligations. If a court were to determine fiduciary obligations apply, we could be subject to claims for breaches of fiduciary obligations or claims we entered into certain prohibited transactions.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third-party service providers utilizing protected personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

The collection, maintenance, protection, use, transmission, disclosure and disposal of protected personal information is regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. These laws, rules and requirements are subject to change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations.

Internationally, many of the jurisdictions in which we operate have established their own data security and privacy legal framework with which we or our customers must comply. We expect there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection and information security in the European Union, Brazil, Chile, India and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers. For example, effective May 2018, the European Union's General Data Protection Regulation (GDPR) overhauled data protection laws in the European Union. The new regulation superseded prior European Union privacy and data protection legislation, imposed more stringent European Union data protection requirements on us or our customers, and prescribed greater penalties for noncompliance. Brazilian privacy legislation, similar in certain respects to GDPR, took effect in August 2020.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard designed to protect payment card account data.

HIPAA requires business associates as well as covered entities to comply with certain privacy and security requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and,

as a result, collect, use, disclose and maintain protected personal information in order to provide services to these customers. HHS administers its audit program to assess HIPAA compliance efforts by covered entities and business associates. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Through our Optum businesses, including our Optum Labs business, we maintain a database of administrative and clinical data statistically de-identified in accordance with HIPAA standards. Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of protected personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business and, among other consequences, could subject us to mandatory disclosure to the media, loss of existing or new customers, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards. Any of these consequences could have a material and adverse effect on our results of operations, financial position and cash flows.

Restrictions on our ability to obtain funds from our regulated subsidiaries could materially and adversely affect our results of operations, financial position and cash flows.

Because we operate as a holding company, we are dependent on dividends and administrative expense reimbursements from our subsidiaries to fund our obligations. Many of these subsidiaries are regulated by state departments of insurance or similar regulatory authorities. We are also required by law or regulation to maintain specific prescribed minimum amounts of capital in these subsidiaries. The levels of capitalization required depend primarily on the volume of premium revenues generated by the applicable subsidiary. In most states, we are required to seek approval by state regulatory authorities before we transfer money or pay dividends from our regulated subsidiaries exceeding specified amounts. An inability of our regulated subsidiaries to pay dividends to their parent companies in the desired amounts or at the time of our choosing could adversely affect our ability to reinvest in our business through capital expenditures or business acquisitions, as well as our ability to maintain our corporate quarterly dividend payment, repurchase shares of our common stock and repay our debt. If we are unable to obtain sufficient funds from our subsidiaries to fund our obligations, our results of operations, financial position and cash flows could be materially and adversely affected.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

To support our business operations in the United States and other countries we own and lease real properties. Our various reportable segments use these facilities for their respective business purposes, and we believe these current facilities are suitable for their respective uses and are adequate for our anticipated future needs.

ITEM 3. LEGAL PROCEEDINGS

The information required by this Item 3 is incorporated herein by reference to the information set forth under the captions “Legal Matters” and “Governmental Investigations, Audits and Reviews” in Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

ITEM 4. MINE SAFETY DISCLOSURES

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

MARKET AND HOLDERS

Our common stock is traded on the New York Stock Exchange (NYSE) under the symbol UNH. On January 29, 2021, there were 11,085 registered holders of record of our common stock.

DIVIDEND POLICY

In June 2020, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.00 compared to $4.32 per share, which the Company had paid since June 2019. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

ISSUER PURCHASES OF EQUITY SECURITIES

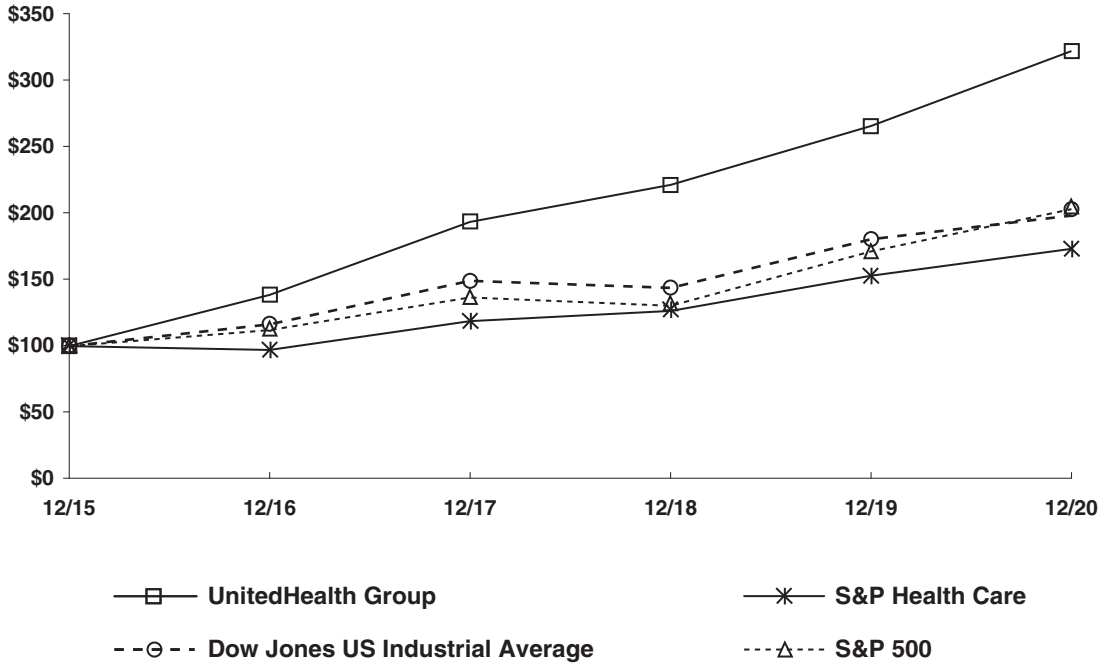
In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. There is no established expiration date for the program. During the fourth quarter of 2020, we repurchased 5.1 million shares at an average price of $334.54 per share. As of December 31, 2020, we had Board authorization to purchase up to 58 million shares of our common stock.

PERFORMANCE GRAPH

The following performance graph compares the cumulative five-year total return to shareholders on our common stock relative to the cumulative total returns of the S&P Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 index for the five-year period ended December 31, 2020. The comparisons assume the investment of $100 on December 31, 2015 in our common stock and in each index, and dividends were reinvested when paid.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among UnitedHealth Group, the S&P Health Care Index, the Dow Jones US Industrial Average Index and the S&P 500 Index



	12/15	12/16	12/17	12/18	12/19	12/20
UnitedHealth Group	**$100.00**	**$138.41**	**$193.52**	**$221.63**	**$265.92**	**$322.31**
S&P Health Care Index	**100.00**	**97.31**	**118.79**	**126.47**	**152.81**	**173.36**
Dow Jones US Industrial Average	**100.00**	**116.50**	**149.24**	**144.05**	**180.56**	**198.11**
S&P 500 Index	**100.00**	**111.96**	**136.40**	**130.42**	**171.49**	**203.04**

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

ITEM 6. SELECTED FINANCIAL DATA

Not applicable.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Consolidated Financial Statements and Notes to the Consolidated Financial Statements thereto included in Part II Item 8, "Financial Statements." Readers are cautioned the statements, estimates, projections or outlook contained in this report, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 7, may constitute forward-looking statements within the meaning of the PSLRA. These forward-looking statements involve risks and uncertainties which may cause our actual results to differ materially from the expectations expressed or implied in the forward-looking statements. A description of some of the risks and uncertainties can be found further below in this Item 7 and in Part I, Item 1A, "Risk Factors."

Discussions of year-over-year comparisons between 2019 and 2018 are not included in this Form 10-K and can be found in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" of the Company's Form 10-K for the fiscal year ended December 31, 2019.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve.

We have four reportable segments across our two business platforms, Optum and UnitedHealthcare:

- OptumHealth;
- OptumInsight;
- OptumRx; and
- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global.

Further information on our business and reportable segments is presented in Part I, Item 1, "Business" and in Note 14 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

COVID-19 Trends and Uncertainties

The COVID-19 pandemic continues to evolve and the ultimate impact on our business, results of operations, financial condition and cash flows remains uncertain. During the second quarter, the global health system experienced unprecedented levels of care deferral, which impacted all of our businesses. As the pandemic advanced, access to and demand for care was most constrained from mid-March through April, began to recover in May and June and restored to near normal seasonal levels in the third quarter. Care patterns continued to normalize in the fourth quarter, returning to, and even exceeding, seasonal baselines, including COVID-19 treatment and testing costs, towards the end of the quarter. The temporary deferral of care experienced in 2020 may cause care patterns to moderately exceed normal baselines in future periods as utilization of health system capacity continues to increase. From time to time, health system capacity may be subject to possible increased volatility due to the pandemic. Specific trends and uncertainties related to our two business platforms are as follows:

Optum. The temporary deferral of care impacted the Optum businesses for the year ended December 31, 2020. For example, our fee-for-service care delivery business, such as traditional procedure work at our ambulatory surgery centers, was negatively impacted, while our risk-based care delivery business performance reflected lower demand for care. Our OptumInsight and OptumRx volume-based businesses were negatively impacted by the lower level of care encounters which took place, as well as by broader economic factors, contributing to lower managed services and prescription volume. As the health system returned to normal seasonally adjusted levels of care, we have seen business activity approach normal levels. COVID-19 will also continue to influence customer and consumer behavior, both during and after the pandemic, which could impact how care is delivered and the manner in which consumers wish to receive their prescription drugs or infusion services. The impact of COVID-19 on our care provider and payer clients could impact the volume and types of services Optum provides, as well as the pacing of potential new business opportunities. As a result of the dynamic situation and broad-reaching impact to the health system, the ultimate impact of COVID-19 on our Optum businesses is uncertain.

UnitedHealthcare. During 2020, we expanded benefit coverage in areas such as COVID-19 care and testing, telemedicine, and pharmacy benefits; provided customers assistance in the form of co-pay waivers and premium forgiveness; offered additional enrollment opportunities to those who previously declined employer-sponsored offerings; extended certain premium payment terms for customers experiencing financial hardship; simplified administrative practices; and accelerated payments to care providers, all with the aim of assisting our customers, care providers, members and communities in addressing the COVID-19 crisis. Temporary care deferrals significantly impacted UnitedHealthcare's results of operations for the year ended December 31, 2020. The impact of temporary care deferrals was offset by COVID-19 related care and testing, the significant financial assistance we provided our customers, rebate requirements and broader economic impacts. Enrollment in our commercial products declined primarily due to employer actions in response to the pandemic.

Increased consumer demand for care, potentially even higher acuity care, along with continued COVID-19 care and testing costs are expected to result in increased future medical costs. Disrupted care patterns, as a result of the pandemic, may temporarily affect the ability to obtain complete member health status information, impacting future revenue in businesses utilizing risk adjustment methodologies. The ultimate overall impact is uncertain and dependent on the future pacing and intensity of the pandemic, the duration of policies and initiatives to address COVID-19, and general economic uncertainty.

Business Trends

Our businesses participate in the United States, South America and certain other international health markets. In the United States, health care spending has grown consistently for many years and comprises 18% of gross domestic product (GDP). We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions, such as the economic impact of COVID-19, and regulatory changes, which could impact our results of operations, including our continued efforts to control health care costs.

Pricing Trends. To price our health care benefit products, we start with our view of expected future costs, including any potential impacts from COVID-19. We frequently evaluate and adjust our approach in each of the local markets we serve, considering relevant factors, such as product positioning, price competitiveness and environmental, competitive, legislative and regulatory considerations, including minimum MLR thresholds. We will continue seeking to balance growth and profitability across all of these dimensions.

The commercial risk market remains highly competitive in both the small group and large group segments. We expect broad-based competition to continue as the industry adapts to individual and employer needs. The ACA had an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally

across the insurance industry for risk-based health insurance products. Pricing for contracts covering some portion of calendar year 2021 reflected the permanent repeal of the Health Insurance Industry Tax.

Medicare Advantage funding continues to be pressured, as discussed below in "Regulatory Trends and Uncertainties."

We expect Medicaid revenue growth due to anticipated changes in mix and increases in the number of people we serve; we also believe the payment rate environment creates the risk of continued downward pressure on Medicaid margin percentages. We continue to take a prudent, market-sustainable posture for both new business and maintenance of existing relationships. We continue to advocate for actuarially sound rates commensurate with our medical cost trends and we remain dedicated to partnering with those states who are committed to the long-term viability of their programs.

Medical Cost Trends. Our medical cost trends primarily relate to changes in unit costs, health system utilization and prescription drug costs. COVID-19 care and testing costs and certain of our customer assistance initiatives have also impacted medical cost trends in the current year and may continue in future years. We endeavor to mitigate those increases by engaging physicians and consumers with information and helping them make clinically sound choices, with the objective of helping them achieve high-quality, affordable care. The uncertain impact of COVID-19 may impact our ability to estimate medical costs payable, which could result in increased variability to medical cost reserve development in future periods.

Delivery System and Payment Modernization. The health care market continues to change based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and improve overall care quality, improve the health of populations and reduce costs. We continue to see a greater number of people enrolled in plans with underlying performance-based care provider payment models rewarding high-quality, affordable care and foster collaboration. We work together with clinicians to leverage our data and analytics to provide the necessary information to close gaps in care and improve overall health outcomes for patients.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of December 31, 2020, we served nearly 18 million people through some form of aligned contractual arrangement, including full-risk, shared-risk and bundled episode-of-care and performance incentive payment approaches.

This trend is creating needs for health management services which can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of the ACA and other regulatory matters. For additional information regarding the ACA and regulatory trends and uncertainties, see Part I, Item 1 "Business—Government Regulation" and Item 1A, "Risk Factors."

Medicare Advantage Rates. Final 2021 Medicare Advantage rates resulted in an increase in industry base rates of approximately 1.7%, short of the industry forward medical cost trend, creating continued pressure in the Medicare Advantage program.

The ongoing Medicare Advantage funding pressure places continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate pressures and reductions. In some years, these adjustments impact the

majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits and implement or increase the member premiums supplementing the monthly payments we receive from the government. Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans.

Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' Star ratings. The level of Star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses.

ACA Tax. After a moratorium in 2019, the industry-wide amount of the Health Insurance Industry Tax for 2020, which was primarily borne by customers, was $15.5 billion, with our portion being approximately $3.0 billion. The return of the tax impacted year-over-year comparability of our financial statements, including revenues, operating costs, medical care ratio (MCR), operating cost ratio, effective tax rate and cash flows from operations. The Health Insurance Industry Tax was permanently repealed by Congress, effective January 1, 2021.

SELECTED OPERATING PERFORMANCE ITEMS

The following represents a summary of select 2020 year-over-year operating comparisons to 2019.

- Consolidated revenues increased by 6%, UnitedHealthcare revenues increased 4% and Optum revenues grew 21%.
- UnitedHealthcare served 420,000 fewer people domestically primarily due to increased unemployment and attrition in commercial group benefits, partially offset by growth in government programs.
- Earnings from operations increased by 14%, including increases of 20% at UnitedHealthcare and 7% at Optum.
- Diluted earnings per common share increased 12% to $16.03.
- Cash flows from operations were $22.2 billion, an increase of 20%.
- Return on equity was 24.9%.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019	
Revenues:					
Premiums	$201,478	$189,699	$178,087	$11,779	6%
Products	34,145	31,597	29,601	2,548	8
Services	20,016	18,973	17,183	1,043	5
Investment and other income	1,502	1,886	1,376	(384)	(20)
Total revenues	257,141	242,155	226,247	14,986	6
Operating costs:					
Medical costs	159,396	156,440	145,403	2,956	2
Operating costs	41,704	35,193	34,074	6,511	19
Cost of products sold	30,745	28,117	26,998	2,628	9
Depreciation and amortization	2,891	2,720	2,428	171	6
Total operating costs	234,736	222,470	208,903	12,266	6
Earnings from operations	22,405	19,685	17,344	2,720	14
Interest expense	(1,663)	(1,704)	(1,400)	41	(2)
Earnings before income taxes	20,742	17,981	15,944	2,761	15
Provision for income taxes	(4,973)	(3,742)	(3,562)	(1,231)	33
Net earnings	15,769	14,239	12,382	1,530	11
Earnings attributable to noncontrolling interests	(366)	(400)	(396)	34	(9)
Net earnings attributable to UnitedHealth Group common shareholders	$ 15,403	$ 13,839	$ 11,986	$ 1,564	11%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 16.03	$ 14.33	$ 12.19	$ 1.70	12%
Medical care ratio (a)	79.1%	82.5%	81.6%	(3.4)%	
Operating cost ratio	16.2	14.5	15.1	1.7	
Operating margin	8.7	8.1	7.7	0.6	
Tax rate	24.0	20.8	22.3	3.2	
Net earnings margin (b)	6.0	5.7	5.3	0.3	
Return on equity (c)	24.9%	25.7%	24.4%	(0.8)%	

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Net earnings margin attributable to UnitedHealth Group shareholders.

(c) Return on equity is calculated as net earnings attributable to UnitedHealth Group common shareholders divided by average shareholders' equity. Average shareholders' equity is calculated using the shareholders' equity balance at the end of the preceding year and the shareholders' equity balances at the end of each of the four quarters of the year presented.

2020 RESULTS OF OPERATIONS COMPARED TO 2019 RESULTS

Consolidated Financial Results

Revenue

The increases in revenue were primarily driven by the increase in the number of individuals served through Medicare Advantage and Medicaid; pricing trends; and organic and acquisition growth across the Optum business, primarily due to expansion in pharmacy care services and care delivery. The increases were partially

offset by decreased individuals served through our commercial and Global benefits businesses, certain voluntary customer assistance programs and rebate requirements. Revenues were also negatively impacted by decreases in our fee-for-service care delivery and other volume-based businesses, primarily as a result of the care deferral and economic impacts of COVID-19.

Medical Costs and MCR

Medical costs increased as a result of growth in people served through Medicare Advantage and Medicaid, medical cost trends and COVID-19 care and testing costs, partially offset by decreased people served in commercial and Global, modestly lower care patterns and increased prior year favorable development. The MCR decreased primarily due to the temporary deferral of care and the revenue effects of the return of the Health Insurance Industry Tax, partially offset by COVID-19 care and testing costs, rebate requirements and voluntary customer assistance measures.

Operating Cost Ratio

The operating cost ratio increased primarily due to the impact of the return of the Health Insurance Industry Tax, COVID-19 response efforts and business mix, partially offset by operating efficiency gains.

Income Tax Rate

Our effective tax rate increased primarily due to the impact of the return of the nondeductible Health Insurance Industry Tax.

Reportable Segments

See Note 14 of Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for more information on our segments. We utilize various metrics to evaluate and manage our reportable segments, including individuals served by UnitedHealthcare by major market segment and funding arrangement, people served by OptumHealth and adjusted scripts for OptumRx. These metrics are the main drivers of revenue, earnings and cash flows at each business. The metrics also allow management and investors to evaluate and understand business mix, customer penetration and pricing trends when comparing the metrics to revenue by segment.

The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019	
Revenues					
UnitedHealthcare	$200,875	$193,842	$183,476	$ 7,033	4%
OptumHealth	39,808	30,317	24,145	9,491	31
OptumInsight	10,802	10,006	9,008	796	8
OptumRx	87,498	74,288	69,536	13,210	18
Optum eliminations	(1,800)	(1,661)	(1,409)	(139)	8
Optum	136,308	112,950	101,280	23,358	21
Eliminations	(80,042)	(64,637)	(58,509)	(15,405)	24
Consolidated revenues	$257,141	$242,155	$226,247	$ 14,986	6%
Earnings from operations					
UnitedHealthcare	$ 12,359	$ 10,326	$ 9,113	$ 2,033	20%
OptumHealth	3,434	2,963	2,430	471	16
OptumInsight	2,725	2,494	2,243	231	9
OptumRx	3,887	3,902	3,558	(15)	—
Optum	10,046	9,359	8,231	687	7
Consolidated earnings from operations	$ 22,405	$ 19,685	$ 17,344	$ 2,720	14%
Operating margin					
UnitedHealthcare	6.2%	5.3%	5.0%	0.9%	
OptumHealth	8.6	9.8	10.1	(1.2)	
OptumInsight	25.2	24.9	24.9	0.3	
OptumRx	4.4	5.3	5.1	(0.9)	
Optum	7.4	8.3	8.1	(0.9)	
Consolidated operating margin	8.7%	8.1%	7.7%	0.6%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenues by business:

(in millions, except percentages)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019	
UnitedHealthcare Employer & Individual	$ 55,872	$ 56,945	$ 54,761	$(1,073)	(2)%
UnitedHealthcare Medicare & Retirement	90,764	83,252	75,473	7,512	9
UnitedHealthcare Community & State	46,487	43,790	43,426	2,697	6
UnitedHealthcare Global	7,752	9,855	9,816	(2,103)	(21)
Total UnitedHealthcare revenues	$200,875	$193,842	$183,476	$ 7,033	4%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	December 31, 2020	2019	2018	Change 2020 vs. 2019	
Commercial:					
Risk-based	7,910	8,575	8,495	(665)	(8)%
Fee-based	18,310	19,185	18,420	(875)	(5)
Total commercial	26,220	27,760	26,915	(1,540)	(6)
Medicare Advantage	5,710	5,270	4,945	440	8
Medicaid	6,620	5,900	6,450	720	12
Medicare Supplement (Standardized)	4,460	4,500	4,545	(40)	(1)
Total public and senior	16,790	15,670	15,940	1,120	7
Total UnitedHealthcare — domestic medical	43,010	43,430	42,855	(420)	(1)
Global	5,425	5,720	6,220	(295)	(5)
Total UnitedHealthcare — medical	48,435	49,150	49,075	(715)	(1)%
Supplemental Data:					
Medicare Part D stand-alone	4,045	4,405	4,710	(360)	(8)%

Fee-based and risk-based commercial business decreased primarily due to increased unemployment and related attrition. Medicare Advantage increased due to growth in people served through individual Medicare Advantage plans. The increase in people served through Medicaid was primarily driven by states easing redetermination requirements due to COVID-19 and growth in people served via Dual Special Needs Plans. The decrease in people served by UnitedHealthcare Global is a result of increased unemployment and underwriting discipline.

UnitedHealthcare's revenue increased due to growth in the number of individuals served through Medicare Advantage and Medicaid, a greater mix of people with higher acuity needs and the return of the Health Insurance Industry Tax, partially offset by a decrease in the number of individuals served through the commercial and Global businesses and foreign currency impacts. In 2020, earnings from operations increased due to the deferral of care caused by COVID-19 on the health system and the factors impacting revenue, partially offset by the return of the Health Insurance Industry Tax, COVID-19 care and testing costs, customer assistance programs and broader economic effects.

Optum

Total revenues increased as each segment reported revenue growth. Earnings from operations increased due to growth at OptumHealth and OptumInsight.

The results by segment were as follows:

OptumHealth

Revenue and earnings at OptumHealth increased primarily due to organic growth and acquisitions in risk-based care delivery. Reduced care volumes in fee-for-service arrangements as a result of COVID-19 partially offset the increases in revenues and earnings. OptumHealth served approximately 98 million people as of December 31, 2020 compared to 96 million people as of December 31, 2019.

OptumInsight

Revenue and earnings from operations at OptumInsight increased primarily due to growth in technology and managed services, partially offset by decreased activity levels in volume-based services due to the impact of COVID-19 on payer and care provider clients.

OptumRx

Revenue at OptumRx and the corresponding eliminations increased due to the inclusion of retail pharmacy co-payments. See Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail. Revenue at OptumRx also increased due to organic and acquisition growth in pharmacy care services, including specialty pharmacy, and new client wins, partially offset by an expected large client transition and lower script volumes driven by COVID-19 related care deferral and fewer people served due to economic-driven employment attrition. Earnings from operations remained relatively flat as COVID-19 impacts were partially offset by the factors impacting revenue and improved supply chain management. OptumRx fulfilled 1.3 billion adjusted scripts in both 2020 and 2019 with growth offset by the large client transition.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to, among other things, minimal levels of statutory capital, as defined by their respective jurisdiction, and restrictions on the timing and amount of dividends paid to their parent companies.

Our U.S. regulated subsidiaries paid their parent companies dividends of $8.3 billion and $5.6 billion in 2020 and 2019, respectively. See Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail concerning our regulated subsidiary dividends.

Our nonregulated businesses also generate significant cash flows from operations available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt and return capital to our shareholders through dividends and repurchases of our common stock.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

(in millions)	For the Years Ended December 31, 2020	2019	2018	Change 2020 vs. 2019
Sources of cash:				
Cash provided by operating activities	$ 22,174	$ 18,463	$ 15,713	$ 3,711
Issuances of long-term debt and short-term borrowings, net of repayments	2,586	3,994	4,134	(1,408)
Proceeds from common share issuances	1,440	1,037	838	403
Customer funds administered	1,677	13	—	1,664
Other	—	219	—	(219)
Total sources of cash	27,877	23,726	20,685	
Uses of cash:				
Cash paid for acquisitions, net of cash assumed	(7,139)	(8,343)	(5,997)	1,204
Cash dividends paid	(4,584)	(3,932)	(3,320)	(652)
Common share repurchases	(4,250)	(5,500)	(4,500)	1,250
Purchases of property, equipment and capitalized software	(2,051)	(2,071)	(2,063)	20
Purchases of investments, net of sales and maturities	(2,836)	(2,504)	(4,099)	(332)
Other	(965)	(1,237)	(1,743)	272
Total uses of cash	(21,825)	(23,587)	(21,722)	
Effect of exchange rate changes on cash and cash equivalents	(116)	(20)	(78)	(96)
Net increase (decrease) in cash and cash equivalents	$ 5,936	$ 119	$ (1,115)	$ 5,817

2020 Cash Flows Compared to 2019 Cash Flows

Increased cash flows provided by operating activities were primarily driven by higher net earnings as well as changes in working capital accounts. Other significant changes in sources or uses of cash year-over-year included an increase in customer funds administered and net purchases of investments, and decreases in net issuances of long-term debt and short-term borrowings, cash paid for acquisitions and share repurchases.

Financial Condition

As of December 31, 2020, our cash, cash equivalent, available-for-sale debt securities and equity securities balances of $59.0 billion included $16.9 billion of cash and cash equivalents (of which $1.3 billion was available for general corporate use), $39.8 billion of debt securities and $2.3 billion of equity securities. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is fully supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 4 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements” for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.7 years and a weighted-average credit rating of “Double A” as of December 31, 2020. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

Cash Requirements. The Company's cash requirements within the next twelve months include medical costs payable, accounts payable and accrued liabilities, commercial paper and current maturities of long-term debt, other current liabilities, and purchase commitments and other obligations. We expect the cash required to meet these obligations to be primarily generated through cash flows from current operations; cash available for general corporate use; and the realization of current assets, such as accounts receivable.

Our long-term cash requirements under our various contractual obligations and commitments include:

- *Debt Obligations.* See Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail of our commercial paper and long-term debt and the timing of expected future payments. Interest coupon payments are typically paid semi-annually.
- *Operating leases*. See Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail of our obligations and the timing of expected future payments.
- *Purchase and other obligations.* These include $5.3 billion, $2.0 billion of which is expected to be paid within the next twelve months, of fixed or minimum commitments under existing purchase obligations for goods and services, including agreements cancelable with the payment of an early termination penalty, and remaining capital commitments for venture capital funds and other funding commitments. These amounts exclude agreements cancelable without penalty and liabilities to the extent recorded in our Consolidated Balance Sheets as of December 31, 2020.
- *Other Liabilities.* These include other long-term liabilities reflected in our Consolidated Balance Sheets as of December 31, 2020, including obligations associated with certain employee benefit programs, unrecognized tax benefits and various long-term liabilities, which have some inherent uncertainty in the timing of these payments.
- *Redeemable noncontrolling interests.* See Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements" for further detail. We do not have any material required redemptions in the next twelve months.

We expect the cash required to meet our long-term obligations to be primarily generated through future cash flows from operations. However, we also have the ability to generate cash to satisfy both our current and long-term requirements through the issuance of commercial paper, issuance of long-term debt, or drawing under our committed credit facilities or the ability to sell investments. We believe our capital resources are sufficient to meet future, short-term and long-term, liquidity needs.

Short-Term Borrowings. Our revolving bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of senior unsecured debt through independent broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Our revolving bank credit facilities contain various covenants, including covenants requiring us to maintain a defined debt to debt-plus-shareholders' equity ratio of not more than 60%, subject to increase in certain circumstances set forth in the applicable credit agreement. As of December 31, 2020, our debt to debt-plus-shareholders' equity ratio, as defined and calculated under the credit facilities, was 38%.

Long-Term Debt. Periodically, we access capital markets to issue long-term debt for general corporate purposes, such as, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases. For more information on our debt, see Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8 "Financial Statements."

Credit Ratings. Our credit ratings as of December 31, 2020 were as follows:

	Moody's		S&P Global		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A+	Stable	A	Stable	A-	Positive
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-1	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. A significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. As of December 31, 2020, we had Board authorization to purchase up to 58 million shares of our common stock. For more information on our share repurchase program, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Dividends. In June 2020, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.00 compared to $4.32 per share, which the Company had paid since June 2019. For more information on our dividend, see Note 10 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

Pending Acquisitions. In the fourth quarter of 2020, we entered into agreements to acquire multiple companies in the health care sector, which are expected to close in the first half of 2021, subject to regulatory approval and other customary closing conditions. Additionally, in January 2021, we entered into agreements to purchase multiple companies in the health care sector, most notably, Change Healthcare (NASDAQ: CHNG). This acquisition is expected to close in the second half of 2021, subject to Change Healthcare shareholders' approval, regulatory approvals and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $13 billion.

We do not have other significant contractual obligations or commitments requiring cash resources. However, we continually evaluate opportunities to expand our operations, which include internal development of new products, programs and technology applications and may include acquisitions.

RECENTLY ISSUED ACCOUNTING STANDARDS

See Note 2 of the Notes to the Consolidated Financial Statements in Part II, Item 8 "Financial Statements" for a discussion of new accounting pronouncements which affect us.

CRITICAL ACCOUNTING ESTIMATES

Critical accounting estimates are those estimates requiring management to make challenging, subjective or complex judgments, often because they must estimate the effects of matters inherently uncertain and may change in subsequent periods. Critical accounting estimates involve judgments and uncertainties which are sufficiently sensitive and may result in materially different results under different assumptions and conditions.

Medical Costs Payable

Medical costs and medical costs payable include estimates of our obligations for medical care services rendered on behalf of insured consumers, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months. As of December 31, 2020, our days outstanding in medical payables was 48 days, calculated as total medical payables divided by total medical costs times the number of days in the period.

In each reporting period, our operating results include the effects of more completely developed medical costs payable estimates associated with previously reported periods. If the revised estimate of prior period medical costs is less than the previous estimate, we will decrease reported medical costs in the current period (favorable development). If the revised estimate of prior period medical costs is more than the previous estimate, we will increase reported medical costs in the current period (unfavorable development). Medical costs in 2020, 2019 and 2018 included favorable medical cost development related to prior years of $880 million, $580 million and $320 million, respectively.

In developing our medical costs payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, for the most recent two months, we estimate claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors.

Completion Factors. A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our medical costs payable estimates for periods prior to the most recent two months. Completion factors include judgments in relation to claim submissions such as the time from date of service to claim receipt, claim levels and processing cycles, as well as other factors. Our judgments also consider the impacts of COVID-19 on these factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for those periods as of December 31, 2020:

Completion Factors (Decrease) Increase in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
(0.75)%	$ 600
(0.50)	399
(0.25)	199
0.25	(198)
0.50	(395)
0.75	(591)

Medical Cost Per Member Per Month Trend Factors. Medical cost PMPM trend factors are significant factors we use in developing our medical costs payable estimates for the most recent two months. Medical cost trend factors are developed through a comprehensive analysis of claims incurred in prior months, provider contracting and expected unit costs, benefit design and a review of a broad set of health care utilization indicators, which included consideration of COVID-19 in 2020. These factors include but are not limited to pharmacy utilization trends, inpatient hospital authorization data and influenza incidence data from the National Centers for Disease Control. We also consider macroeconomic variables such as GDP growth, employment and disposable income. A large number of factors can cause the medical cost trend to vary from our estimates, including: our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co-pays and deductibles, changes in medical practices, catastrophes, epidemics and pandemics, such as COVID-19.

The following table illustrates the sensitivity of these factors and the estimated potential impact on our medical costs payable estimates for the most recent two months as of December 31, 2020:

Medical Cost PMPM Quarterly Trend Increase (Decrease) in Factors	Increase (Decrease) In Medical Costs Payable
	(in millions)
3%	$ 793
2	529
1	264
(1)	(264)
(2)	(529)
(3)	(793)

The completion factors and medical costs PMPM trend factors analyses above include outcomes considered reasonably likely based on our historical experience estimating liabilities for incurred but not reported benefit claims.

Management believes the amount of medical costs payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2020; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2020 estimates of medical costs payable and actual medical costs payable, excluding AARP Medicare Supplement Insurance and any potential offsetting impact from premium rebates, 2020 net earnings would have increased or decreased by approximately $157 million.

For more detail related to our medical cost estimates, see Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, “Financial Statements.”

Goodwill

We evaluate goodwill for impairment annually or more frequently when an event occurs or circumstances change indicating the carrying value may not be recoverable. When testing goodwill for impairment, we may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. During a qualitative analysis, we consider the impact of changes, if any, to the following factors: macroeconomic, industry and market factors, cost factors, changes in overall financial performance, and any other relevant events and uncertainties impacting a reporting unit. If our qualitative assessment indicates a goodwill impairment is more likely than not, we perform additional quantitative analyses. We may also elect to skip the qualitative testing and proceed directly to the quantitative testing. For reporting units where a quantitative analysis is performed, we perform a test measuring the fair values of the reporting units and comparing them to their aggregate carrying values, including goodwill. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

We estimate the fair values of our reporting units using a discounted cash flow method or a weighted combination of discounted cash flows and a market-based method. The discounted cash flow method includes assumptions about a wide variety of internal and external factors. Significant assumptions used in the discounted cash flow method include financial projections of free cash flow, including revenue trends, medical costs trends, operating productivity, income taxes and capital levels; long-term growth rates for determining terminal value beyond the discretely forecasted periods; and discount rates. Financial projections and long-term growth rates used for our reporting units are consistent with, and use inputs from, our internal long-term business plan and strategies. Discount rates are determined for each reporting unit and include consideration of the implied risk inherent in their forecasts. Our most significant estimate in the discount rate determinations involves our adjustments to the peer company weighted average costs of capital reflecting reporting unit-specific factors.

We have not made any adjustments to decrease a discount rate below the calculated peer company weighted average cost of capital for any reporting unit. Company-specific adjustments to discount rates are subjective and thus are difficult to measure with certainty. The passage of time and the availability of additional information regarding areas of uncertainty with respect to the reporting units' operations could cause these assumptions to change in the future. Additionally, as part of our quantitative impairment testing, we perform various sensitivity analyses on certain key assumptions, such as discount rates, cash flow projections and peer company multiples to analyze the potential for a material impact. The market-based method requires determination of appropriate peer group whose securities are traded on an active market. The peer group is used to derive market multiples to estimate fair value. As of October 1, 2020, we completed our annual impairment tests for goodwill with all of our reporting units having fair values substantially in excess of their carrying values.

LEGAL MATTERS

A description of our legal proceedings is presented in Note 12 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

CONCENTRATIONS OF CREDIT RISK

Investments in financial instruments such as marketable securities and accounts receivable may subject us to concentrations of credit risk. Our investments in marketable securities are managed under an investment policy authorized by our Board of Directors. This policy limits the amounts which may be invested in any one issuer and generally limits our investments to U.S. government and agency securities, state and municipal securities and corporate debt obligations of investment grade. Concentrations of credit risk with respect to accounts receivable are limited due to the large number of employer groups and other customers constituting our client base. As of December 31, 2020, there were no significant concentrations of credit risk.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to changes in interest rates impacting our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, as well as foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and Chilean peso.

As of December 31, 2020, we had $20 billion of financial assets on which the interest rates received vary with market interest rates, which may significantly impact our investment income. Also as of December 31, 2020, $8 billion of our financial liabilities, which include commercial paper, debt and deposit liabilities, were at interest rates which vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of our fixed-rate investments and debt also varies with market interest rates. As of December 31, 2020, $37 billion of our investments were fixed-rate debt securities and $45 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed-income market sectors and debt across maturities, as well as by matching a portion of our floating-rate assets and liabilities, either directly or through the use of interest rate swap contracts. Unrealized gains and losses on investments in available-for-sale debt securities are reported in comprehensive income.

The following tables summarize the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of December 31, 2020 and 2019 on our investment income and interest expense per annum and the fair value of our investments and debt (in millions, except percentages):

	December 31, 2020			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 401	$ 163	$ (3,020)	$ (8,700)
1	201	82	(1,499)	(4,744)
(1)	(75)	(12)	820	5,266
(2)	(75)	(12)	886	8,101

	December 31, 2019			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum	Interest Expense Per Annum	Fair Value of Financial Assets	Fair Value of Financial Liabilities
2%	$ 282	$ 185	$ (2,668)	$ (6,813)
1	141	93	(1,331)	(3,704)
(1)	(141)	(93)	1,246	4,433
(2)	(282)	(185)	2,071	9,613

Note: Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of December 31, 2020, the assumed hypothetical change in interest rates does not reflect the full 100 and 200 basis point reduction in interest income or interest expense, as the rates are assumed not to fall below zero. As of December 31, 2020 and 2019, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of foreign currencies, primarily the Brazilian real and the Chilean peso, to the U.S. dollar in translation of UnitedHealthcare Global's operating results at the average exchange rate over the accounting period, and UnitedHealthcare Global's assets and liabilities at the exchange rate at the end of the accounting period. The gains or losses resulting from translating foreign assets and liabilities into U.S. dollars are included in equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real or Chilean peso reduces the carrying value of the net assets denominated in those currencies. For example, as of December 31, 2020, a hypothetical 10% and 25% increase in the value of the U.S. dollar against those currencies would have caused a reduction in net assets of approximately $535 million and $1.2 billion, respectively. We manage exposure to foreign currency earnings risk primarily by conducting our international business operations in their functional currencies.

As of December 31, 2020, we had $2.3 billion of investments in equity securities, primarily consisting of investments in employee savings plan related investments and non-U.S. dollar fixed-income funds. Valuations in non-U.S. dollar funds are subject to foreign exchange rates.

ITEM 8. FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2020 and 2019, the related consolidated statements of operations, comprehensive income, changes in equity and cash flows for each of the three years in the period ended December 31, 2020, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2020, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 1, 2021 expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current-period audit of the financial statements that were communicated or required to be communicated to the audit committee and that (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Incurred but not Reported (IBNR) Claim Liability—Refer to Notes 2 and 7 to the financial statements.

Critical Audit Matter Description

Medical costs payable includes estimates of the Company's obligations for medical care services rendered on behalf of insured consumers, for which claims have either not yet been received or processed. These estimates

are referred to as incurred but not reported (IBNR) claim liabilities. The Company develops IBNR estimates using an actuarial model that requires management to exercise certain judgments in developing its estimates. Judgments made by management include medical cost per member per month trend factors and completion factors, which include assumptions over the time from date of service to claim receipt, the impact of claim levels, and processing cycles.

We identified the IBNR claim liability as a critical audit matter because of the significant assumptions made by management in estimating the liability. This required complex auditor judgment, and an increased extent of effort, including the involvement of actuarial specialists in performing procedures to evaluate the reasonableness of management's methods, assumptions and judgments in developing the liability.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures included the following, among others:

- We tested the effectiveness of controls over management's estimate of the IBNR claim liability balance, including controls over the judgments in both the completion factors and the medical cost per member per month trend factors.
- We tested the underlying claims and membership data and other information that served as the basis for the actuarial analysis, to test that the inputs to the actuarial estimate were complete and accurate.
- With the assistance of actuarial specialists, we evaluated the reasonableness of the actuarial methods and assumptions used by management to estimate the IBNR claim liability by:
    - Performing an overlay of the historical claims data used in management's current year model to the data used in prior periods to validate that there were no material changes to the claims data tested in prior periods.
    - Developing an independent estimate of the IBNR claim liability and comparing our estimate to management's estimate.
    - Performing a retrospective review comparing management's prior year estimate of IBNR to claims processed in 2020 with dates of service in 2019 or prior.

Goodwill—Refer to Notes 2 and 6 to the financial statements.

Critical Audit Matter Description

At December 31, 2020, the Company's goodwill balance was $71 billion. As discussed in Note 2 of the financial statements, for reporting units where a quantitative analysis is performed, the Company performs an annual impairment test measuring the fair values of the reporting units and comparing them to their aggregate carrying values including goodwill. The estimates of the reporting unit fair values are calculated using a discounted cash flow method or a weighted combination of discounted cash flows and a market-based method. The discounted cash flow method includes assumptions about revenue trends, medical cost trends, and operating costs as well as discount rates. The market-based method requires determination of an appropriate group of peer companies whose securities are traded on an active market. The fair values of the reporting units exceeded the carrying values as of the impairment testing date, therefore no impairment was recognized.

We identified a critical audit matter related to the quantitative analysis performed for such reporting units because of the significant assumptions made by management to estimate the fair value of the reporting unit. This required increased auditor judgment and extent of effort, including involvement of fair value specialists to evaluate the reasonableness of management's estimates and assumptions related to peer company selection and financial projections, which can be impacted by regulatory and macro-economic factors.

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to the valuation, business, and market assumptions including the discount rate, financial forecasts, and peer group used by management to estimate the fair value of reporting units where a quantitative analysis was performed, included the following, among others:

- We tested the effectiveness of controls over management's annual goodwill impairment assessment, including those over the determination of the fair value such as controls related to management's financial forecasts, as well as controls over the selection of discount rates, company specific risks, peer companies, and market multiples.
- We evaluated management's ability to forecast and meet future revenue, medical cost trend, and operating costs by comparing:
  - Actual results to historical forecasts.
  - Forecasted information to: internal communications to management and the Board of Directors, industry and economic trends, and analyst reports of revenue and earnings expectations for the Company and its peers.
- We evaluated the impact of changes in management's forecasts from the October 1, 2020 annual measurement date to December 31, 2020.
- We evaluated management's selection of peer companies and market multiples.
- With the assistance of our fair value specialists, we evaluated the reasonableness of the (1) valuation methodologies, including testing the mathematical accuracy of the calculation, (2) the weighting of such valuation methodologies, and (3) discount rate and company specific risks by:
  - Testing the source information underlying the determination of the discount rate and the mathematical accuracy of the calculation.
  - Developing a range of independent discount rate estimates and comparing to those selected by management.

/S/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
March 1, 2021

We have served as the Company's auditor since 2002.

UnitedHealth Group
Consolidated Balance Sheets

(in millions, except per share data)	December 31, 2020	December 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 16,921	$ 10,985
Short-term investments	2,860	3,260
Accounts receivable, net of allowances of $990 and $519	12,870	11,822
Other current receivables, net of allowances of $1,047 and $859	12,534	9,640
Assets under management	4,076	3,076
Prepaid expenses and other current assets	4,457	3,851
Total current assets	53,718	42,634
Long-term investments	41,242	37,209
Property, equipment and capitalized software, net of accumulated depreciation and amortization of $5,230 and $4,995	8,626	8,704
Goodwill	71,337	65,659
Other intangible assets, net of accumulated amortization of $5,455 and $5,072	10,856	10,349
Other assets	11,510	9,334
Total assets	$ 197,289	$ 173,889
Liabilities, redeemable noncontrolling interests and equity		
Current liabilities:		
Medical costs payable	$ 21,872	$ 21,690
Accounts payable and accrued liabilities	22,495	19,005
Short-term borrowings and current maturities of long-term debt	4,819	3,870
Unearned revenues	2,842	2,622
Other current liabilities	20,392	14,595
Total current liabilities	72,420	61,782
Long-term debt, less current maturities	38,648	36,808
Deferred income taxes	3,367	2,993
Other liabilities	12,315	10,144
Total liabilities	126,750	111,727
Commitments and contingencies (Note 12)		
Redeemable noncontrolling interests	2,211	1,726
Equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 946 and 948 issued and outstanding	10	9
Additional paid-in capital	—	7
Retained earnings	69,295	61,178
Accumulated other comprehensive loss	(3,814)	(3,578)
Nonredeemable noncontrolling interests	2,837	2,820
Total equity	68,328	60,436
Total liabilities, redeemable noncontrolling interests and equity	$ 197,289	$ 173,889

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Operations

(in millions, except per share data)	For the Years Ended December 31, 2020	2019	2018
Revenues:			
Premiums	$201,478	$189,699	$178,087
Products	34,145	31,597	29,601
Services	20,016	18,973	17,183
Investment and other income	1,502	1,886	1,376
Total revenues	257,141	242,155	226,247
Operating costs:			
Medical costs	159,396	156,440	145,403
Operating costs	41,704	35,193	34,074
Cost of products sold	30,745	28,117	26,998
Depreciation and amortization	2,891	2,720	2,428
Total operating costs	234,736	222,470	208,903
Earnings from operations	22,405	19,685	17,344
Interest expense	(1,663)	(1,704)	(1,400)
Earnings before income taxes	20,742	17,981	15,944
Provision for income taxes	(4,973)	(3,742)	(3,562)
Net earnings	15,769	14,239	12,382
Earnings attributable to noncontrolling interests	(366)	(400)	(396)
Net earnings attributable to UnitedHealth Group common shareholders	$ 15,403	$ 13,839	$ 11,986
Earnings per share attributable to UnitedHealth Group common shareholders:			
Basic	$ 16.23	$ 14.55	$ 12.45
Diluted	$ 16.03	$ 14.33	$ 12.19
Basic weighted-average number of common shares outstanding	949	951	963
Dilutive effect of common share equivalents	12	15	20
Diluted weighted-average number of common shares outstanding	961	966	983
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	8	10	6

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2020	2019	2018
Net earnings	$15,769	$14,239	$12,382
Other comprehensive (loss) income:			
Gross unrealized gains (losses) on investment securities during the period	1,058	1,212	(294)
Income tax effect	(253)	(279)	67
Total unrealized gains (losses), net of tax	805	933	(227)
Gross reclassification adjustment for net realized gains included in net earnings	(75)	(104)	(62)
Income tax effect	17	24	14
Total reclassification adjustment, net of tax	(58)	(80)	(48)
Total foreign currency translation losses	(983)	(271)	(1,242)
Other comprehensive (loss) income	(236)	582	(1,517)
Comprehensive income	15,533	14,821	10,865
Comprehensive income attributable to noncontrolling interests	(366)	(400)	(396)
Comprehensive income attributable to UnitedHealth Group common shareholders	$15,167	$14,421	$10,469

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Changes in Equity

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income: Net Unrealized (Losses) Gains on Investments	Accumulated Other Comprehensive (Loss) Income: Foreign Currency Translation Losses	Nonredeemable Noncontrolling Interests	Total Equity
Balance at January 1, 2018	969	$ 10	$ 1,703	$ 48,730	$ (13)	$ (2,654)	$ 2,057	$ 49,833
Adjustment to adopt ASU 2016-01				(24)	24			—
Net earnings				11,986			273	12,259
Other comprehensive loss					(275)	(1,242)		(1,517)
Issuances of common stock, and related tax effects	10	—	814					814
Share-based compensation			620					620
Common share repurchases	(19)	—	(2,974)	(1,526)				(4,500)
Cash dividends paid on common shares ($3.45 per share)				(3,320)				(3,320)
Redeemable noncontrolling interest fair value and other adjustments			(163)					(163)
Acquisition and other adjustments of nonredeemable noncontrolling interests							521	521
Distributions to nonredeemable noncontrolling interest							(228)	(228)
Balance at December 31, 2018	960	10	—	55,846	(264)	(3,896)	2,623	54,319
Adjustment to adopt ASU 2016-02				(13)			(5)	(18)
Net earnings				13,839			285	14,124
Other comprehensive income (loss)					853	(271)		582
Issuances of common stock, and related tax effects	10	—	696					696
Share-based compensation			673					673
Common share repurchases	(22)	(1)	(937)	(4,562)				(5,500)
Cash dividends paid on common shares ($4.14 per share)				(3,932)				(3,932)
Redeemable noncontrolling interest fair value and other adjustments			(316)					(316)
Acquisition and other adjustments of nonredeemable noncontrolling interests			(109)				196	87
Distributions to nonredeemable noncontrolling interest							(279)	(279)
Balance at December 31, 2019	948	9	7	61,178	589	(4,167)	2,820	60,436
Adjustment to adopt ASU 2016-13				(28)				(28)
Net earnings				15,403			254	15,657
Other comprehensive income (loss)					747	(983)		(236)
Issuances of common stock, and related tax effects	12	1	1,119					1,120
Share-based compensation			647					647
Common share repurchases	(14)	—	(1,576)	(2,674)				(4,250)
Cash dividends paid on common shares ($4.83 per share)				(4,584)				(4,584)
Redeemable noncontrolling interests fair value and other adjustments			(197)					(197)
Acquisition and other adjustments of nonredeemable noncontrolling interests							40	40
Distributions to nonredeemable noncontrolling interests							(277)	(277)
Balance at December 31, 2020	946	$ 10	$ —	$ 69,295	$ 1,336	$ (5,150)	$ 2,837	$ 68,328

See Notes to the Consolidated Financial Statements

UnitedHealth Group
Consolidated Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2020	2019	2018
Operating activities			
Net earnings	$ 15,769	$ 14,239	$ 12,382
Noncash items:			
Depreciation and amortization	2,891	2,720	2,428
Deferred income taxes	(8)	230	42
Share-based compensation	679	697	638
Other, net	(52)	(106)	(71)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:			
Accounts receivable	(688)	162	(1,351)
Other assets	(2,195)	(1,563)	(750)
Medical costs payable	152	1,221	1,831
Accounts payable and other liabilities	5,348	733	526
Unearned revenues	278	130	38
Cash flows from operating activities	22,174	18,463	15,713
Investing activities			
Purchases of investments	(16,577)	(18,131)	(14,010)
Sales of investments	6,489	8,536	3,641
Maturities of investments	7,252	7,091	6,270
Cash paid for acquisitions, net of cash assumed	(7,139)	(8,343)	(5,997)
Purchases of property, equipment and capitalized software	(2,051)	(2,071)	(2,063)
Other, net	(506)	219	(226)
Cash flows used for investing activities	(12,532)	(12,699)	(12,385)
Financing activities			
Common share repurchases	(4,250)	(5,500)	(4,500)
Cash dividends paid	(4,584)	(3,932)	(3,320)
Proceeds from common stock issuances	1,440	1,037	838
Repayments of long-term debt	(3,150)	(1,750)	(2,600)
Proceeds from (repayments of) short-term borrowings, net	872	300	(201)
Proceeds from issuance of long-term debt	4,864	5,444	6,935
Customer funds administered	1,677	13	(131)
Other, net	(459)	(1,237)	(1,386)
Cash flows used for financing activities	(3,590)	(5,625)	(4,365)
Effect of exchange rate changes on cash and cash equivalents	(116)	(20)	(78)
Increase (decrease) in cash and cash equivalents	5,936	119	(1,115)
Cash and cash equivalents, beginning of period	10,985	10,866	11,981
Cash and cash equivalents, end of period	$ 16,921	$ 10,985	$ 10,866
Supplemental cash flow disclosures			
Cash paid for interest	$ 1,704	$ 1,627	$ 1,410
Cash paid for income taxes	4,935	3,542	3,257

See Notes to the Consolidated Financial Statements

1. Description of Business

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health care company with a mission to help people live healthier lives and help make the health system work better for everyone. Our two complementary businesses—Optum and UnitedHealthcare—are driven by this unified mission and vision to improve health care access, affordability, experiences and outcomes for the individuals and organizations we are privileged to serve.

2. Basis of Presentation, Use of Estimates and Significant Accounting Policies

Basis of Presentation

The Company has prepared the Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries.

Use of Estimates

These Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and goodwill. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Revenues

Premiums

Premium revenues are primarily derived from risk-based health insurance arrangements in which the premium is typically at a fixed rate per individual served for a one-year period, and the Company assumes the economic risk of funding its customers' health care and related administrative costs.

Premium revenues are recognized in the period in which eligible individuals are entitled to receive health care benefits. Health care premium payments received from the Company's customers in advance of the service period are recorded as unearned revenues. Fully insured commercial products of U.S. health plans, Medicare Advantage and Medicare Prescription Drug Benefit (Medicare Part D) plans with medical loss ratios (MLRs) as calculated under the definitions in the Patient Protection and Affordable Care Act (ACA) and related federal and state regulations and implementing regulation, falling below certain targets are required to rebate ratable portions of their premiums annually. Commercial premiums within the Company's individual and small group markets are also subject to the ACA risk adjustment program. Medicare Advantage premium revenue includes the impact of the Centers for Medicare & Medicaid Services (CMS) quality bonuses based on plans' Star rating. Certain of the Company's Medicaid business is also subject to state minimum MLR rebates.

Premium revenues are recognized based on the estimated premiums earned, net of projected rebates, because the Company is able to reasonably estimate the ultimate premiums of these contracts. The Company also records premium revenues for certain risk-based arrangements at its OptumHealth care delivery businesses.

The Company's Medicare Advantage and Medicare Part D premium revenues are subject to periodic adjustment under CMS' risk adjustment payment methodology. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model provides higher per member payments for enrollees diagnosed with certain conditions and lower payments for enrollees who are healthier. Under this risk adjustment methodology, CMS calculates the risk

adjusted premium payment using diagnosis and encounter data from hospital inpatient, hospital outpatient and physician treatment settings. The Company and health care providers collect, capture and submit the necessary and available data to CMS within prescribed deadlines. The Company estimates risk adjustment premium revenues based upon the data submitted and expected to be submitted to CMS. Risk adjustment data for the Company's plans are subject to review by the government, including audit by regulators. See Note 12 for additional information regarding these audits.

Products and Services

For the Company's OptumRx pharmacy care services business, the majority of revenues are derived from products sold through a contracted network of retail pharmacies or home delivery, specialty and community health pharmacies. Product revenues include the cost of pharmaceuticals (net of rebates), a negotiated dispensing fee and customer co-payments for drugs dispensed through the Company's home delivery, specialty and community pharmacies. For the year ended December 31, 2020, the Company recognized revenue and cost of products sold for retail pharmacy co-payments related to its OptumRx business. Revenue recognized in prior periods related to retail pharmacy transactions excludes the member's applicable co-payment. There was no impact on earnings from operations, net earnings, earnings per share or total equity. Pharmacy products are billed to customers based on the number of transactions occurring during the billing period. Product revenues are recognized when the prescriptions are dispensed. The Company has entered into contracts in which it is primarily obligated to pay its network pharmacy providers for benefits provided to their customers regardless of whether the Company is paid. The Company is also involved in establishing the prices charged by retail pharmacies, determining which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members and accordingly, are reported on a gross basis.

Services revenue consists of fees derived from services performed for customers who self-insure the health care costs of their employees and employees' dependents. Under service fee contracts, the Company receives monthly, a fixed fee per employee, which is recognized as revenue as the Company performs, or makes available, the applicable services to the customer. 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 premium revenue and medical costs for these contracts in its Consolidated Financial Statements. For these fee-based customer arrangements, the Company provides coordination and facilitation of medical services; transaction processing; customer, consumer and care professional services; and access to contracted networks of physicians, hospitals and other health care professionals. These services are performed throughout the contract period.

Revenues are also comprised of a number of services and products sold through Optum. OptumHealth's service revenues include net patient service revenues recorded based upon established billing rates, less allowances for contractual adjustments, and are recognized as services are provided. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds. OptumInsight provides software and information products, advisory consulting arrangements and managed services outsourcing contracts, which may be delivered over several years. OptumInsight revenues are generally recognized over time and measured each period based on the progress to date as services are performed or made available to customers.

As of December 31, 2020 and 2019, accounts receivables related to products and services were $5.3 billion and $4.3 billion, respectively. In 2020 and 2019, the Company had no material bad-debt expense and there were no material contract assets, contract liabilities or deferred contract costs recorded on the Consolidated Balance Sheets as of December 31, 2020 or 2019.

For the years ended December 31, 2020 and 2019, revenue recognized from performance obligations related to prior periods (for example, due to changes in transaction price) was not material.

Revenue expected to be recognized in any future year related to remaining performance obligations, excluding revenue pertaining to contracts having an original expected duration of one year or less, contracts where revenue is recognized as invoiced and contracts with variable consideration related to undelivered performance obligations, is not material.

See Note 14 for disaggregation of revenue by segment and type.

Medical Costs and Medical Costs Payable

The Company's estimate of medical costs payable represents management's best estimate of its liability for unpaid medical costs as of December 31, 2020.

Each period, the Company re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As more complete claim information becomes available, the Company adjusts the amount of the estimates and includes the changes in estimates in medical costs in the period in which the change is identified. Approximately 90% of claims related to medical care services are known and settled within 90 days from the date of service and substantially all within twelve months.

Medical costs and medical costs payable include estimates of the Company's obligations for medical care services rendered on behalf of insured consumers, but for which claims have either not yet been received, processed, or paid. The Company develops estimates for medical care services incurred but not reported (IBNR), which includes estimates for claims which have not been received or fully processed, using an actuarial process consistently applied, centrally controlled and automated. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies, benefit plan changes, and business mix changes related to products, customers and geography. Judgments related to these factors contemplated the impact of COVID-19 in 2020.

In developing its medical costs payable estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. For the most recent two months, the Company estimates claim costs incurred by applying observed medical cost trend factors to the average per member per month (PMPM) medical costs incurred in prior months for which more complete claim data are available, supplemented by a review of near-term completion factors (actuarial estimates, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period adjudicated by the Company at the date of estimation). For months prior to the most recent two months, the Company applies the completion factors to actual claims adjudicated-to-date to estimate the expected amount of ultimate incurred claims for those months.

Cost of Products Sold

The Company's cost of products sold includes the cost of pharmaceuticals dispensed to unaffiliated customers either directly at its home delivery, specialty and community pharmacy locations, or indirectly through its nationwide network of participating pharmacies. Rebates attributable to non-affiliated clients are accrued as rebates receivable and a reduction of cost of products sold, with a corresponding payable for the amounts of the rebates to be remitted to those non-affiliated clients in accordance with their contracts and recorded in the Consolidated Statements of Operations as a reduction of product revenue. Cost of products sold also includes the cost of personnel to support the Company's transaction processing services, system sales, maintenance and professional services.

Cash, Cash Equivalents and Investments

Cash and cash equivalents are highly liquid investments having an original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Investments with maturities of less than one year are classified as short-term. Because of regulatory requirements, certain investments are included in long-term investments regardless of their maturity date. The Company classifies these investments as held-to-maturity and reports them at amortized cost. Substantially all other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available. Equity investments, with certain exceptions, are measured at fair value with changes in fair value recognized in net earnings.

The Company excludes unrealized gains and losses on investments in available-for-sale debt securities from net earnings and reports them as comprehensive income and, net of income tax effects, as a separate component of equity. To calculate realized gains and losses on the sale of debt securities, the Company specifically identifies the cost of each investment sold.

The Company evaluates an available-for-sale debt security for credit-related impairment by considering the present value of expected cash flows relative to a security's amortized cost, the extent to which fair value is less than amortized cost, the financial condition and near-term prospects of the issuer and specific events or circumstances which may influence the operations of the issuer. Credit-related impairments are recorded as an allowance, with an offset to investment and other income. Non-credit related impairments are recorded through other comprehensive income. If the Company intends to sell an impaired security, or will likely be required to sell a security before recovery of the entire amortized cost, the entire impairment is included in net earnings.

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the Company's investment policy.

Assets Under Management

The Company provides health insurance products and services to members of 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, hospital indemnity insurance, including insurance for individuals between 50 to 64 years of age, and other related products.

Pursuant to the Company's agreement with AARP, program assets are managed separately from the Company's general investment portfolio and are used to pay costs associated with the AARP Program. These assets are invested at the Company's discretion, within investment guidelines approved by AARP. The Company does not guarantee any rates of return on these investments and, upon any transfer of the AARP Program contract to another entity, the Company would transfer cash equal in amount to the fair value of these investments at the date of transfer to the entity. Because the purpose of these assets is to fund the medical costs payable, the rate stabilization fund (RSF) liabilities and other related liabilities associated with this AARP contract, assets under management are classified as current assets, consistent with the classification of these liabilities.

The effects of changes in other balance sheet amounts associated with the AARP Program also accrue to the overall benefit of the AARP policyholders through the RSF balance. Accordingly, the Company excludes the effect of such changes in its Consolidated Statements of Cash Flows.

Other Current Receivables

Other current receivables include amounts due from pharmaceutical manufacturers for rebates and Medicare Part D drug discounts, accrued interest and other miscellaneous amounts due to the Company.

The Company's pharmacy care services businesses contract with pharmaceutical manufacturers, some of which provide rebates based on use of the manufacturers' products by its affiliated and non-affiliated clients. The Company accrues rebates as they are earned by its clients on a monthly basis based on the terms of the applicable contracts, historical data and current estimates. The pharmacy care services businesses bill these rebates to the manufacturers on a monthly or quarterly basis depending on the contractual terms and record rebates attributable to affiliated clients as a reduction to medical costs. The Company generally receives rebates two to five months after billing. As of December 31, 2020 and 2019, total pharmaceutical manufacturer rebates receivable included in other receivables in the Consolidated Balance Sheets amounted to $6.3 billion and $4.7 billion, respectively.

As of December 31, 2020 and 2019, the Company's Medicare Part D receivables amounted to $2.9 billion and $2.3 billion, respectively.

Property, Equipment and Capitalized Software

Property, equipment and capitalized software are stated at cost, net of accumulated depreciation and amortization. Capitalized software consists of certain costs incurred in the development of internal-use software, including external direct costs of materials and services and applicable payroll costs of employees devoted to specific software development.

The Company calculates depreciation and amortization using the straight-line method over the estimated useful lives of the assets. The useful lives for property, equipment and capitalized software are:

Furniture, fixtures and equipment	3 to 10 years
Buildings	35 to 40 years
Capitalized software	3 to 5 years

Leasehold improvements are depreciated over the shorter of the remaining lease term or their estimated useful economic life.

Operating Leases

The Company leases facilities and equipment under long-term operating leases which are non-cancelable and expire on various dates. At the lease commencement date, lease right-of-use (ROU) assets and lease liabilities are recognized based on the present value of the future minimum lease payments over the lease term, which includes all fixed obligations arising from the lease contract. If an interest rate is not implicit in a lease, the Company utilizes its incremental borrowing rate for a period closely matching the lease term.

The Company's ROU assets are included in other assets, and lease liabilities are included in other current liabilities and other liabilities in the Company's Consolidated Balance Sheet.

Goodwill

To determine whether goodwill is impaired, annually or more frequently if needed, the Company performs impairment tests. The Company may first assess qualitative factors to determine if it is more likely than not the carrying value of a reporting unit exceeds its estimated fair value. The Company may also elect to skip the qualitative testing and proceed directly to the quantitative testing. When performing quantitative testing, the Company first estimates the fair values of its reporting units using discounted cash flows or a weighted

combination of discounted cash flows and a market-based method. To determine fair values, the Company must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, discount rates and the selection of comparable peer companies. If the fair value is less than the carrying value of the reporting unit, an impairment is recognized for the difference, up to the carrying amount of goodwill.

There was no impairment of goodwill during the year ended December 31, 2020.

Intangible Assets

The Company's intangible assets are subject to impairment tests when events or circumstances indicate an intangible asset (or asset group) may be impaired. The Company's indefinite-lived intangible assets are also tested for impairment annually. There was no impairment of intangible assets during the year ended December 31, 2020.

Other Current Liabilities

Other current liabilities include health savings account deposits ($10.2 billion and $8.3 billion as of December 31, 2020 and 2019, respectively), the RSF associated with the AARP Program, accruals for premium rebates payable, the current portion of future policy benefits and customer balances.

Policy Acquisition Costs

The Company's short duration health insurance contracts typically have a one-year term and may be canceled by the customer with at least 30 days' notice. Costs related to the acquisition and renewal of short duration customer contracts are primarily charged to expense as incurred.

Redeemable Noncontrolling Interests

Redeemable noncontrolling interests in the Company's subsidiaries whose redemption is outside the control of the Company are classified as temporary equity. The following table provides details of the Company's redeemable noncontrolling interests' activity for the years ended December 31, 2020 and 2019:

(in millions)	2020	2019
Redeemable noncontrolling interests, beginning of period	$1,726	$1,908
Net earnings	112	115
Acquisitions	321	90
Redemptions	—	(618)
Distributions	(149)	(69)
Fair value and other adjustments	201	300
Redeemable noncontrolling interests, end of period	$2,211	$1,726

Share-Based Compensation

The Company recognizes compensation expense for share-based awards, including stock options and restricted stock and restricted stock units (collectively, restricted shares), on a straight-line basis over the related service period (generally the vesting period) of the award, or to an employee's eligible retirement date under the award agreement, if earlier. Restricted shares vest ratably, primarily over four years and compensation expense related to restricted shares is based on the share price on the date of grant. Stock options vest ratably primarily over four years and may be exercised up to 10 years from the date of grant. Compensation expense related to stock options

is based on the fair value at the date of grant, which is estimated on the date of grant using a binomial option-pricing model. Under the Company's Employee Stock Purchase Plan (ESPP), eligible employees are allowed to purchase the Company's stock at a discounted price, which is 90% of the market price of the Company's common stock at the end of the six-month purchase period. Share-based compensation expense for all programs is recognized in operating costs in the Consolidated Statements of Operations.

Net Earnings Per Common Share

The Company computes basic earnings per common share attributable to UnitedHealth Group common shareholders by dividing net earnings attributable to UnitedHealth Group common shareholders by the weighted-average number of common shares outstanding during the period. The Company determines diluted net earnings per common share attributable to UnitedHealth Group common shareholders using the weighted-average number of common shares outstanding during the period, adjusted for potentially dilutive shares associated with stock options, restricted shares and the ESPP (collectively, common stock equivalents), using the treasury stock method. The treasury stock method assumes a hypothetical issuance of shares to settle the share-based awards, with the assumed proceeds used to purchase common stock at the average market price for the period. Assumed proceeds include the amount the employee must pay upon exercise and the average unrecognized compensation cost. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

ACA Tax

The ACA included an annual, nondeductible insurance industry tax (Health Insurance Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products. After a moratorium in 2019, the industry wide amount of the Health Insurance Industry Tax for 2020, which was primarily borne by the customer, was $15.5 billion, of which the Company's portion was approximately $3.0 billion. The Health Insurance Industry Tax was permanently repealed by Congress, effective January 1, 2021.

Recently Adopted Accounting Standards

In June 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standard Update (ASU) No. 2016-13, "Financial Instruments—Credit Losses (Topic 326)" (ASU 2016-13). ASU 2016-13 requires the use of the current expected credit loss impairment model to develop an estimate of expected credit losses for certain financial assets. ASU 2016-13 also requires expected credit losses on available-for-sale debt securities to be recognized through an allowance for credit losses and revises certain disclosure requirements. The Company adopted ASU 2016-13 on January 1, 2020 using a cumulative effect upon adoption approach. The adoption of ASU 2016-13 was immaterial to the Company's consolidated balance sheet, results of operations, equity and cash flows.

The Company has determined there have been no other recently adopted or issued accounting standards which had, or will have, a material impact on its Consolidated Financial Statements.

3. Investments

A summary of debt securities by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2020				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,335	$ 133	$ (3)	$ 3,465
State and municipal obligations	6,893	435	—	7,328
Corporate obligations	18,886	863	(12)	19,737
U.S. agency mortgage-backed securities	6,849	245	(3)	7,091
Non-U.S. agency mortgage-backed securities	2,116	95	(4)	2,207
Total debt securities — available-for-sale	38,079	1,771	(22)	39,828
Debt securities — held-to-maturity:				
U.S. government and agency obligations	420	6	—	426
State and municipal obligations	31	2	—	33
Corporate obligations	187	1	—	188
Total debt securities — held-to-maturity	638	9	—	647
Total debt securities	$ 38,717	$ 1,780	$ (22)	$ 40,475
December 31, 2019				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 3,502	$ 55	$ (4)	$ 3,553
State and municipal obligations	5,680	251	(5)	5,926
Corporate obligations	17,910	343	(11)	18,242
U.S. agency mortgage-backed securities	6,425	109	(6)	6,528
Non-U.S. agency mortgage-backed securities	1,811	37	(3)	1,845
Total debt securities — available-for-sale	35,328	795	(29)	36,094
Debt securities — held-to-maturity:				
U.S. government and agency obligations	402	2	—	404
State and municipal obligations	32	2	—	34
Corporate obligations	538	—	(1)	537
Total debt securities — held-to-maturity	972	4	(1)	975
Total debt securities	$ 36,300	$ 799	$ (30)	$ 37,069

Nearly all of the Company's investments in mortgage-backed securities were rated "Triple A" as of December 31, 2020.

The Company held $2.3 billion and $2.0 billion of equity securities as of December 31, 2020 and December 31, 2019, respectively. The Company's investments in equity securities primarily consist of employee savings plan related investments and shares of Brazilian real denominated fixed-income funds with readily determinable fair values. Additionally, the Company's investments included $1.3 billion and $1.4 billion of equity method investments in operating businesses in the health care sector, as of December 31, 2020 and 2019, respectively. The allowance for credit losses on held-to-maturity securities at December 31, 2020 was not material.

The amortized cost and fair value of debt securities as of December 31, 2020, by contractual maturity, were as follows:

	Available-for-Sale		Held-to-Maturity	
(in millions)	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Due in one year or less	$ 2,951	$ 2,966	$ 348	$ 349
Due after one year through five years	11,638	12,088	241	245
Due after five years through ten years	10,212	10,931	27	29
Due after ten years	4,313	4,545	22	24
U.S. agency mortgage-backed securities	6,849	7,091	—	—
Non-U.S. agency mortgage-backed securities	2,116	2,207	—	—
Total debt securities	$ 38,079	$ 39,828	$ 638	$ 647

The fair value of available-for-sale debt securities with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	Less Than 12 Months		12 Months or Greater		Total	
(in millions)	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
December 31, 2020						
U.S. government and agency obligations	$ 346	$ (3)	$ —	$ —	$ 346	$ (3)
Corporate obligations	1,273	(9)	456	(3)	1,729	(12)
U.S. agency mortgage-backed securities	601	(3)	—	—	601	(3)
Non-U.S. agency mortgage-backed securities	195	(1)	93	(3)	288	(4)
Total debt securities — available-for-sale	$ 2,415	$ (16)	$ 549	$ (6)	$ 2,964	$ (22)
December 31, 2019						
U.S. government and agency obligations	$ 616	$ (4)	$ —	$ —	$ 616	$ (4)
State and municipal obligations	440	(5)	—	—	440	(5)
Corporate obligations	1,903	(7)	740	(4)	2,643	(11)
U.S. agency mortgage-backed securities	657	(3)	333	(3)	990	(6)
Non-U.S. agency mortgage-backed securities	406	(3)	—	—	406	(3)
Total debt securities — available-for-sale	$ 4,022	$ (22)	$ 1,073	$ (7)	$ 5,095	$ (29)

The Company's unrealized losses from all securities as of December 31, 2020 were generated from approximately 2,000 positions out of a total of 36,000 positions. The Company believes it will collect the timely principal and interest due on its debt securities having an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities which impacted the Company's assessment on collectability of principal and interest. At each reporting period, the Company evaluates available-for-sale debt securities for any credit-related impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the expected cash flows, the underlying credit quality and credit ratings of the issuers, and the potential economic impacts of COVID-19 on the issuers, noting no significant credit deterioration since purchase. As of December 31, 2020, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary. The allowance for credit losses on available-for-sale debt securities at December 31, 2020 was not material.

4. Fair Value

Certain assets and liabilities are measured at fair value in the Consolidated Financial Statements or have fair values disclosed in the Notes to the Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input which 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.

The fair value hierarchy is summarized as follows:

Level 1—Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2—Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in inactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs corroborated by other observable market data.

Level 3—Unobservable inputs cannot be corroborated by observable market data.

There were no transfers in or out of Level 3 financial assets or liabilities during the years ended December 31, 2020 or 2019.

Nonfinancial assets and liabilities or financial assets and liabilities measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2020 or 2019.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments which do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. 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 third-party pricing service (pricing service), which generally uses quoted 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 currently observable in the markets for similar securities. Inputs often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding 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 to the prices obtained from the pricing service.

Fair values of debt securities which do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in corporate bonds, which are not a significant portion of our investments, are estimated using valuation techniques relying heavily on management assumptions and qualitative observations.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on such understanding.

Assets Under Management. Assets under management consists of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Long-Term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
December 31, 2020				
Cash and cash equivalents	$ 16,841	$ 80	$ —	$16,921
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,241	224	—	3,465
State and municipal obligations	—	7,328	—	7,328
Corporate obligations	25	19,424	288	19,737
U.S. agency mortgage-backed securities	—	7,091	—	7,091
Non-U.S. agency mortgage-backed securities	—	2,207	—	2,207
Total debt securities — available-for-sale	3,266	36,274	288	39,828
Equity securities	1,795	33	—	1,828
Assets under management	1,774	2,250	52	4,076
Total assets at fair value	$ 23,676	$ 38,637	$ 340	$62,653
Percentage of total assets at fair value	38%	61%	1%	100%
December 31, 2019				
Cash and cash equivalents	$ 10,837	$ 148	$ —	$10,985
Debt securities — available-for-sale:				
U.S. government and agency obligations	3,369	184	—	3,553
State and municipal obligations	—	5,926	—	5,926
Corporate obligations	70	17,923	249	18,242
U.S. agency mortgage-backed securities	—	6,528	—	6,528
Non-U.S. agency mortgage-backed securities	—	1,845	—	1,845
Total debt securities — available-for-sale	3,439	32,406	249	36,094
Equity securities	1,734	22	—	1,756
Assets under management	1,123	1,918	35	3,076
Total assets at fair value	$ 17,133	$ 34,494	$ 284	$51,911
Percentage of total assets at fair value	33%	66%	1%	100%

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
December 31, 2020					
Debt securities — held-to-maturity	$ 466	$ 108	$ 73	$ 647	$ 638
Long-term debt and other financing obligations	$ —	$ 51,254	$ —	$ 51,254	$ 42,171
December 31, 2019					
Debt securities — held-to-maturity	$ 541	$ 181	$ 253	$ 975	$ 972
Long-term debt and other financing obligations	$ —	$ 45,078	$ —	$ 45,078	$ 40,278

The carrying amounts reported on the Consolidated Balance Sheets for other current financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

5. Property, Equipment and Capitalized Software

A summary of property, equipment and capitalized software is as follows:

(in millions)	December 31, 2020	December 31, 2019
Land and improvements	$ 533	$ 589
Buildings and improvements	4,759	4,705
Computer equipment	1,767	2,015
Furniture and fixtures	1,787	1,752
Less accumulated depreciation	(3,364)	(3,328)
Property and equipment, net	5,482	5,733
Capitalized software	5,010	4,638
Less accumulated amortization	(1,866)	(1,667)
Capitalized software, net	3,144	2,971
Total property, equipment and capitalized software, net	$ 8,626	$ 8,704

Depreciation expense for property and equipment for the years ended December 31, 2020, 2019 and 2018 was $997 million, $995 million and $924 million, respectively. Amortization expense for capitalized software for the years ended December 31, 2020, 2019 and 2018 was $814 million, $721 million and $606 million, respectively.

6. Goodwill and Other Intangible Assets

Changes in the carrying amount of goodwill, by reportable segment, were as follows:

(in millions)	UnitedHealthcare	OptumHealth	OptumInsight	OptumRx	Consolidated
Balance at January 1, 2019	$ 26,400	$ 11,947	$ 5,772	$ 14,791	$ 58,910
Acquisitions	1,022	3,395	2,521	6	6,944
Foreign currency effects and other adjustments, net	(194)	—	(1)	—	(195)
Balance at December 31, 2019	27,228	15,342	8,292	14,797	65,659
Acquisitions	1,180	4,500	—	699	6,379
Foreign currency effects and other adjustments, net	(623)	2	(119)	39	(701)
Balance at December 31, 2020	$ 27,785	$ 19,844	$ 8,173	$ 15,535	$ 71,337

The gross carrying value, accumulated amortization and net carrying value of other intangible assets were as follows:

(in millions)	December 31, 2020			December 31, 2019		
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Customer-related	$ 13,428	$ (4,575)	$ 8,853	$ 12,968	$ (4,319)	$ 8,649
Trademarks and technology	1,597	(624)	973	1,186	(525)	661
Trademarks and other indefinite-lived	680	—	680	726	—	726
Other	606	(256)	350	541	(228)	313
Total	$ 16,311	$ (5,455)	$ 10,856	$ 15,421	$ (5,072)	$10,349

The acquisition date fair values and weighted-average useful lives assigned to finite-lived intangible assets acquired in business combinations consisted of the following by year of acquisition:

(in millions, except years)	2020		2019	
	Fair Value	Weighted-Average Useful Life	Fair Value	Weighted-Average Useful Life
Customer-related	$1,113	11 years	$1,750	13 years
Trademarks and technology	514	10 years	163	5 years
Other	95	10 years	119	11 years
Total acquired finite-lived intangible assets	$1,722	11 years	$2,032	13 years

Estimated full year amortization expense relating to intangible assets for each of the next five years ending December 31 is as follows:

(in millions)	
2021	$1,105
2022	998
2023	933
2024	887
2025	850

Amortization expense relating to intangible assets for the years ended December 31, 2020, 2019 and 2018 was $1.1 billion, $1.0 billion and $898 million, respectively.

7. Medical Costs Payable

The following table shows the components of the change in medical costs payable for the years ended December 31:

(in millions)	2020	2019	2018
Medical costs payable, beginning of period	$ 21,690	$ 19,891	$ 17,871
Acquisitions	316	679	339
Reported medical costs:			
Current year	160,276	157,020	145,723
Prior years	(880)	(580)	(320)
Total reported medical costs	159,396	156,440	145,403
Medical payments:			
Payments for current year	(139,974)	(137,155)	(127,155)
Payments for prior years	(19,556)	(18,165)	(16,567)
Total medical payments	(159,530)	(155,320)	(143,722)
Medical costs payable, end of period	$ 21,872	$ 21,690	$ 19,891

For the years ended December 31, 2020 and 2019 medical cost reserve development was primarily driven by lower than expected health system utilization levels. For the year ended December 31, 2018, no individual factors significantly impacted medical cost reserve development. Medical costs payable included IBNR of $14.8 billion and $13.8 billion at December 31, 2020 and 2019, respectively. Substantially all of the IBNR balance as of December 31, 2020 relates to the current year.

The following is information about incurred and paid medical cost development as of December 31, 2020:

(in millions)	Net Incurred Medical Costs For the Years Ended December 31,	
Year	2019	2020
2019	$ 157,020	$ 156,217
2020		160,276
Total		$ 316,493

(in millions)	Net Cumulative Medical Payments For the Years Ended December 31,	
Year	2019	2020
2019	$ (137,155)	$ (155,150)
2020		(139,974)
Total		(295,124)
Net remaining outstanding liabilities prior to 2019		503
Total medical costs payable		$ 21,872

8. Short-Term Borrowings and Long-Term Debt

Short-term borrowings and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	December 31, 2020			December 31, 2019		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 1,296	$ 1,296	$ 1,296	$ 400	$ 400	$ 400
2.700% notes due July 2020	—	—	—	1,500	1,499	1,506
Floating rate notes due October 2020	—	—	—	300	300	300
3.875% notes due October 2020	—	—	—	450	450	455
1.950% notes due October 2020	—	—	—	900	899	900
4.700% notes due February 2021	400	400	401	400	403	410
2.125% notes due March 2021	750	750	753	750	749	753
Floating rate notes due June 2021	350	350	350	350	349	350
3.150% notes due June 2021	400	400	405	400	399	407
3.375% notes due November 2021	500	507	509	500	501	512
2.875% notes due December 2021	750	762	768	750	753	765
2.875% notes due March 2022	1,100	1,113	1,127	1,100	1,087	1,121
3.350% notes due July 2022	1,000	999	1,048	1,000	998	1,036
2.375% notes due October 2022	900	897	935	900	896	911
0.000% notes due November 2022	15	14	14	15	13	14
2.750% notes due February 2023	625	644	654	625	624	638
2.875% notes due March 2023	750	789	793	750	770	770
3.500% notes due June 2023	750	748	809	750	747	786
3.500% notes due February 2024	750	747	821	750	746	792
2.375% notes due August 2024	750	747	799	750	747	760
3.750% notes due July 2025	2,000	1,992	2,279	2,000	1,990	2,161
3.700% notes due December 2025	300	298	344	300	298	325
1.250% notes due January 2026	500	496	515	—	—	—
3.100% notes due March 2026	1,000	997	1,121	1,000	996	1,048
3.450% notes due January 2027	750	747	859	750	746	804
3.375% notes due April 2027	625	620	714	625	620	667
2.950% notes due October 2027	950	940	1,067	950	939	988
3.850% notes due June 2028	1,150	1,143	1,367	1,150	1,142	1,269
3.875% notes due December 2028	850	844	1,019	850	843	941
2.875% notes due August 2029	1,000	1,086	1,137	1,000	993	1,029
2.000% notes due May 2030	1,250	1,234	1,326	—	—	—
4.625% notes due July 2035	1,000	992	1,340	1,000	992	1,215
5.800% notes due March 2036	850	839	1,271	850	838	1,129
6.500% notes due June 2037	500	492	800	500	492	712
6.625% notes due November 2037	650	641	1,044	650	641	940
6.875% notes due February 2038	1,100	1,077	1,802	1,100	1,076	1,631
3.500% notes due August 2039	1,250	1,241	1,487	1,250	1,241	1,313
2.750% notes due May 2040	1,000	964	1,085	—	—	—
5.700% notes due October 2040	300	296	451	300	296	396
5.950% notes due February 2041	350	346	540	350	345	475
4.625% notes due November 2041	600	589	820	600	589	716
4.375% notes due March 2042	502	485	661	502	484	580
3.950% notes due October 2042	625	608	790	625	607	688
4.250% notes due March 2043	750	735	982	750	735	856
4.750% notes due July 2045	2,000	1,974	2,814	2,000	1,973	2,463
4.200% notes due January 2047	750	738	991	750	738	861
4.250% notes due April 2047	725	717	963	725	717	839
3.750% notes due October 2047	950	934	1,180	950	934	1,023
4.250% notes due June 2048	1,350	1,330	1,803	1,350	1,330	1,569
4.450% notes due December 2048	1,100	1,086	1,517	1,100	1,086	1,316
3.700% notes due August 2049	1,250	1,235	1,567	1,250	1,235	1,344
2.900% notes due May 2050	1,250	1,208	1,384	—	—	—
3.875% notes due August 2059	1,250	1,228	1,618	1,250	1,228	1,350
3.125% notes due May 2060	1,000	965	1,161	—	—	—
Total short-term borrowings and long-term debt	$42,563	$42,280	$51,301	$39,817	$39,474	$44,234

The Company's long-term debt obligations also included $1.2 billion of other financing obligations as of both December 31, 2020 and 2019, of which $354 million and $322 million were current as of December 31, 2020 and 2019, respectively.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2021	$ 4,800
2022	3,180
2023	2,290
2024	1,665
2025	2,465
Thereafter	29,349

Short-Term Borrowings

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of December 31, 2020, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.2%.

The Company has $4.4 billion five-year, $4.4 billion three-year and $3.8 billion 364-day revolving bank credit facilities with 26 banks, which mature in December 2025, December 2023 and December 2021, respectively. These facilities provide full liquidity support for the Company's commercial paper program and are available for general corporate purposes. As of December 31, 2020, no amounts had been drawn on any of the bank credit facilities. The annual interest rates, which are variable based on term, are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. If amounts had been drawn on the bank credit facilities as of December 31, 2020, annual interest rates would have ranged from 0.8% to 1.0%.

Debt Covenants

The Company's bank credit facilities contain various covenants, including requiring the Company to maintain a debt to debt-plus-shareholders' equity ratio of not more than 60%. The Company was in compliance with its debt covenants as of December 31, 2020.

9. Income Taxes

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year, excluding any deferred income tax assets and liabilities of acquired businesses. The components of the provision for income taxes for the years ended December 31 are as follows:

(in millions)	2020	2019	2018
Current Provision:			
Federal	$4,098	$2,629	$2,897
State and local	392	319	219
Foreign	491	564	404
Total current provision	4,981	3,512	3,520
Deferred (benefit) provision	(8)	230	42
Total provision for income taxes	$4,973	$3,742	$3,562

The reconciliation of the tax provision at the U.S. federal statutory rate to the provision for income taxes and the effective tax rate for the years ended December 31 is as follows:

(in millions, except percentages)	2020		2019		2018	
Tax provision at the U.S. federal statutory rate	$4,356	21.0%	$3,776	21.0%	$3,348	21.0%
State income taxes, net of federal benefit	315	1.5	271	1.5	168	1.0
Share-based awards — excess tax benefit	(130)	(0.6)	(132)	(0.7)	(161)	(1.0)
Non-deductible compensation	134	0.7	119	0.7	117	0.7
Health insurance tax	626	3.0	—	—	552	3.5
Foreign rate differential	(164)	(0.8)	(214)	(1.2)	(203)	(1.3)
Other, net	(164)	(0.8)	(78)	(0.5)	(259)	(1.6)
Provision for income taxes	$4,973	24.0%	$3,742	20.8%	$3,562	22.3%

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities as of December 31 are as follows:

(in millions)	2020	2019
Deferred income tax assets:		
Accrued expenses and allowances	$ 815	$ 654
U.S. federal and state net operating loss carryforwards	276	260
Share-based compensation	98	97
Nondeductible liabilities	252	184
Non-U.S. tax loss carryforwards	340	420
Lease liability	1,200	892
Other-domestic	126	179
Other-non-U.S.	454	329
Subtotal	3,561	3,015
Less: valuation allowances	(170)	(147)
Total deferred income tax assets	3,391	2,868
Deferred income tax liabilities:		
U.S. federal and state intangible assets	(2,588)	(2,370)
Non-U.S. goodwill and intangible assets	(606)	(735)
Capitalized software	(731)	(683)
Depreciation and amortization	(346)	(301)
Prepaid expenses	(216)	(172)
Outside basis in partnerships	(342)	(317)
Lease right-of-use asset	(1,179)	(887)
Net unrealized gains on investments	(400)	(177)
Other-non-U.S.	(350)	(219)
Total deferred income tax liabilities	(6,758)	(5,861)
Net deferred income tax liabilities	$(3,367)	$(2,993)

Valuation allowances are provided when it is considered more likely than not deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and non-U.S. net operating loss carryforwards. Gross federal net operating loss carryforwards of $100 million expire beginning in 2023 through 2037 and $309 million have an indefinite carryforward period; state net operating loss carryforwards expire beginning in 2021 through 2040, with some having an indefinite carryforward period. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

As of December 31, 2020, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded. Taxes payable on the remittance of such earnings would be minimal.

A reconciliation of the beginning and ending amount of unrecognized tax benefits as of December 31 is as follows:

(in millions)	2020	2019	2018
Gross unrecognized tax benefits, beginning of period	$1,423	$1,056	$ 598
Gross increases:			
Current year tax positions	416	512	487
Prior year tax positions	120	2	87
Gross decreases:			
Prior year tax positions	(130)	(96)	(84)
Settlements	—	(46)	(20)
Statute of limitations lapses	—	(5)	(12)
Gross unrecognized tax benefits, end of period	$1,829	$1,423	$1,056

The Company believes it is reasonably possible its liability for unrecognized tax benefits will decrease in the next twelve months by $39 million as a result of audit settlements and the expiration of statutes of limitations.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Consolidated Statements of Operations. During the years ended December 31, 2020, 2019 and 2018, the Company recognized $52 million, $19 million and $6 million of interest and penalties, respectively. The Company had $128 million and $76 million of accrued interest and penalties for uncertain tax positions as of December 31, 2020 and 2019, respectively. These amounts are not included in the reconciliation above. As of December 31, 2020, there were $1.0 billion of unrecognized tax benefits which, if recognized, would affect the effective tax rate.

The Company currently files income tax returns in the United States, various states and localities and non-U.S. jurisdictions. The U.S. Internal Revenue Service (IRS) has completed exams on the consolidated income tax returns for fiscal years 2016 and prior. The Company's 2017 through 2020 tax years are under review by the IRS under its Compliance Assurance Program. With the exception of a few states, the Company is no longer subject to income tax examinations prior to the 2013 tax year. In general, the Company is subject to examination in non-U.S. jurisdictions for years 2015 and forward.

10. Shareholders' Equity

Regulatory Capital and Dividend Restrictions

The Company's regulated insurance and health maintenance organization (HMO) subsidiaries are subject to regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions which may be paid to their parent companies. In the United States, most of these state regulations and standards are generally consistent with model regulations established by the National Association of Insurance Commissioners. These standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, it is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the year ended December 31, 2020, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $8.3 billion, including $4.2 billion of extraordinary dividends. For the year ended December 31, 2019, the Company's domestic insurance and HMO subsidiaries paid their parent companies dividends of $5.6 billion, including $1.3 billion of extraordinary dividends.

The Company's global financially regulated subsidiaries had estimated aggregate statutory capital and surplus of $29.6 billion as of December 31, 2020. The estimated statutory capital and surplus necessary to satisfy regulatory requirements of the Company's global financially regulated subsidiaries was approximately $11.9 billion as of December 31, 2020.

Optum Bank must meet minimum capital requirements of the Federal Deposit Insurance Corporation (FDIC) under the capital adequacy rules to which it is subject. At December 31, 2020, the Company believes Optum Bank met the FDIC requirements to be considered "Well Capitalized."

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2018, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock.

A summary of common share repurchases for the years ended December 31, 2020 and 2019 is as follows:

	Years Ended December 31,	
(in millions, except per share data)	**2020**	**2019**
Common share repurchases, shares	14	22
Common share repurchases, average price per share	$ 300.58	$ 245.97
Common share repurchases, aggregate cost	$ 4,250	$ 5,500
Board authorized shares remaining	58	72

Dividends

In June 2020, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to an annual rate of $5.00 compared to $4.32 per share, which the Company had paid since June 2019. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2020 dividend payments:

Payment Date	**Amount per Share**	**Total Amount Paid**
		(in millions)
March 24	$ 1.08	$ 1,024
June 30	1.25	1,188
September 22	1.25	1,188
December 15	1.25	1,184

11. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of non-qualified stock options and restricted shares. In June 2020, the Company's Board of Directors approved 48 million additional shares under the Plan.

As of December 31, 2020, the Company had 71 million shares available for future grants of share-based awards under the Plan. As of December 31, 2020, there were also 4 million shares of common stock available for issuance under the ESPP.

Stock Options

Stock option activity for the year ended December 31, 2020 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	32	$ 166		
Granted	7	311		
Exercised	(10)	126		
Forfeited	(1)	255		
Outstanding at end of period	28	211	6.6	$ 3,937
Exercisable at end of period	13	150	5.0	2,579
Vested and expected to vest, end of period	27	210	6.5	3,892

Restricted Shares

Restricted share activity for the year ended December 31, 2020 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	5	$ 207
Granted	1	303
Vested	(2)	187
Nonvested at end of period	4	256

Other Share-Based Compensation Data

	For the Years Ended December 31,		
(in millions, except per share amounts)	2020	2019	2018
Stock Options			
Weighted-average grant date fair value of shares granted, per share	$ 54	$ 46	$ 43
Total intrinsic value of stock options exercised	1,736	1,398	1,431
Restricted Shares			
Weighted-average grant date fair value of shares granted, per share	303	259	229
Total fair value of restricted shares vested	$ 574	$ 545	$ 521
Employee Stock Purchase Plan			
Number of shares purchased	1	1	2
Share-Based Compensation Items			
Share-based compensation expense, before tax	$ 679	$ 697	$ 638
Share-based compensation expense, net of tax effects	619	641	587
Income tax benefit realized from share-based award exercises	208	201	239

(in millions, except years)	December 31, 2020
Unrecognized compensation expense related to share awards	$ 805
Weighted-average years to recognize compensation expense	1.4

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options were as follows:

	For the Years Ended December 31,		
	2020	2019	2018
Risk-free interest rate	0.2% - 1.4%	1.5% - 2.5%	2.6% - 3.1%
Expected volatility	22.2% - 29.5%	19.4% - 21.6%	18.7% - 19.3%
Expected dividend yield	1.4% - 1.7%	1.4% - 1.8%	1.3% - 1.5%
Forfeiture rate	5.0%	5.0%	5.0%
Expected life in years	5.1	5.3	5.6

Risk-free interest rates are based on U.S. Treasury yields in effect at the time of grant. Expected volatilities are based on the historical volatility of the Company's common stock and the implied volatility from exchange-traded options on the Company's common stock. Expected dividend yields are based on the per share cash dividend paid by the Company. The Company uses historical data to estimate option exercises and forfeitures within the valuation model. The expected lives of options granted represents the period of time the awards granted are expected to be outstanding based on historical exercise patterns.

Other Employee Benefit Plans

The Company offers a 401(k) plan for its employees. Compensation expense related to this plan was not material for 2020, 2019 and 2018.

In addition, the Company maintains non-qualified, deferred compensation plans, which allow certain members of senior management and executives to defer portions of their salary or bonus. The deferrals are recorded within long-term investments with an approximately equal amount in other liabilities in the Consolidated Balance Sheets. The total deferrals are distributable based upon termination of employment or other periods, as elected under each plan and were $1.6 billion and $1.4 billion as of December 31, 2020 and 2019, respectively.

12. Commitments and Contingencies

Leases

Operating lease costs were $1.1 billion, $1.0 billion and $751 million for the years ended December 31, 2020, 2019 and 2018, respectively, and included immaterial variable and short-term lease costs for the year ended December 31, 2020 and 2019. Cash payments made on the Company's operating lease liabilities were $865 million and $746 million for the years ended December 31, 2020 and 2019, respectively, which were classified within operating activities in the Consolidated Statements of Cash Flows. As of December 31, 2020, the Company's weighted-average remaining lease term and weighted-average discount rate for its operating leases were 8.7 years and 3.0%, respectively.

As of December 31, 2020, future minimum annual lease payments under all non-cancelable operating leases were as follows:

(in millions)	Future Minimum Lease Payments
2021	$ 865
2022	775
2023	646
2024	538
2025	441
Thereafter	1,781
Total future minimum lease payments	5,046
Less imputed interest	(599)
Total	$ 4,447

Other Commitments

The Company provides guarantees related to its service level under certain contracts. If minimum standards are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2020, 2019 or 2018.

As of December 31, 2020, the Company had outstanding, undrawn letters of credit with financial institutions of $134 million and surety bonds outstanding with insurance companies of $1.2 billion, primarily to bond contractual performance.

Pending Acquisitions

In the fourth quarter of 2020, the Company entered into agreements to acquire multiple companies in the health care sector, which are expected to close in the first half of 2021, subject to regulatory approval and other customary closing conditions. Additionally, in January 2021, the Company entered into agreements to purchase multiple companies in the health care sector, most notably, Change Healthcare (NASDAQ: CHNG). This acquisition is expected to close in the second half of 2021, subject to Change Healthcare shareholders' approval, regulatory approvals and other customary closing conditions. The total anticipated capital required for these acquisitions, excluding the payoff of acquired indebtedness, is approximately $13 billion.

Legal Matters

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. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims and claims related to health care benefits coverage and other business practices.

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 a loss may be incurred.

Government Investigations, Audits and Reviews

The Company has been involved 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, state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice (DOJ), the SEC, the IRS, the U.S. Drug Enforcement Administration, the U.S. Department of Labor, the FDIC, the Defense Contract Audit Agency and other governmental authorities. Similarly, our international businesses are also subject to investigations, audits and reviews by applicable foreign governments, including South American and other non-U.S. governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other matters, compliance with coding and other requirements under the Medicare risk-adjustment model. CMS has selected certain of the Company's local plans for risk adjustment data validation (RADV) audits to validate the coding practices of and supporting documentation maintained by health care providers and such audits may result in retrospective adjustments to payments made to the Company's health plans.

On February 14, 2017, the 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 the Company made improper risk adjustment submissions and violated the False Claims Act. On February 12, 2018, the court granted in part and denied in part the Company's motion to dismiss. In May 2018, DOJ moved to dismiss the Company's counterclaims, which were filed in March 2018, and moved for partial summary judgment. In March 2019, the court denied the government's motion for partial summary judgment and dismissed the Company's counterclaims without prejudice. The Company cannot reasonably estimate the outcome which may result from this matter given its procedural status.

13. Business Combinations

During the year ended December 31, 2020, the Company completed several business combinations for total cash consideration of $7.9 billion.

The total consideration exceeded the fair value of the net tangible assets acquired by $8.1 billion, of which $1.7 billion has been allocated to finite-lived intangible assets and $6.4 billion to goodwill. The majority of goodwill is not deductible for income tax purposes.

Acquired tangible assets (liabilities) at acquisition date were:

(in millions)	
Cash and cash equivalents	$ 715
Accounts receivable and other current assets	735
Property, equipment and other long-term assets	816
Medical costs payable	(316)
Accounts payable and other current liabilities	(861)
Other long-term liabilities	(817)
Total net tangible assets	$ 272

The preliminary purchase price allocations for the various business combinations are subject to adjustment as valuation analyses, primarily related to intangible assets and contingent and tax liabilities, are finalized. See Note 6 for a summary of the acquisition date fair values and weighted-average useful lives assigned to acquired finite-lived intangible assets.

The results of operations and financial condition of acquired entities have been included in the Company's consolidated results and the results of the corresponding operating segment as of date of acquisition. Through December 31, 2020, acquired entities impact on revenue and net earnings was not material.

Unaudited pro forma revenues for the years ended December 31, 2020 and 2019 as if the acquisitions had occurred on January 1, 2019 were immaterial for both periods. The pro forma effects of the acquisitions on net earnings were immaterial for both years.

14. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes which operate in a similar regulatory environment are combined.

The following is a description of the types of products and services from which each of the Company's four reportable segments derives its revenues:

- *UnitedHealthcare* includes the combined results of operations of UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global. The U.S. businesses share significant common assets, including a contracted network of physicians, health care professionals, hospitals and other facilities, information technology and consumer engagement infrastructure and other resources. UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services for large national employers, public sector employers, mid-sized employers, small businesses and individuals nationwide. UnitedHealthcare Medicare & Retirement provides health care coverage and health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services as well as services dealing with chronic disease and other specialized issues for older individuals. UnitedHealthcare Community & State provides diversified health care benefits products and services to state programs caring for the economically disadvantaged and the medically underserved. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, the Children's Health Insurance Program and other federal, state and community health care programs. UnitedHealthcare Global provides health and dental benefits and hospital and clinical services to employer groups and individuals in South America, and other diversified global health businesses.
- *OptumHealth* focuses on care delivery, care management, wellness and consumer engagement, and health financial services. OptumHealth is building a comprehensive, connected health care delivery and engagement platform by directly providing high-quality care, helping people manage chronic and complex health needs, and proactively engaging consumers in managing their health through in-person, virtual and digital clinical platforms. OptumHealth offers access to networks of care provider specialists, health management services, care delivery, consumer engagement and financial services.
- *OptumInsight* brings together advanced analytics, technology and health care expertise to deliver integrated services and solutions. Hospital systems, physicians, health plans, governments, life sciences companies and other organizations comprising the health care industry depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.
- *OptumRx* offers pharmacy care services and programs, including retail network contracting, home delivery, specialty and community health pharmacy services, purchasing and clinical capabilities, and develops programs in areas such as step therapy, formulary management, drug adherence and disease/drug therapy management. OptumRx integrates pharmacy and medical care and is positioned to serve patients with complex clinical needs and consumers looking for a better digital pharmacy experience with transparent pricing.

The Company's accounting policies for reportable segment operations are consistent with those described in the Summary of Significant Accounting Policies (see Note 2). Transactions between reportable segments principally consist of sales of pharmacy care products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and local care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Transactions with affiliated customers are eliminated in consolidation. Assets and liabilities jointly used are assigned to each reportable segment using estimates of pro-rata usage. Cash and investments are assigned so each reportable segment has working capital and/or at least minimum specified levels of regulatory capital.

As a percentage of the Company's total consolidated revenues, premium revenues from CMS were 36%, 33% and 30% for 2020, 2019 and 2018, respectively, most of which were generated by UnitedHealthcare Medicare & Retirement and included in the UnitedHealthcare segment. U.S. customer revenue represented approximately 97%, 96% and 96% of consolidated total revenues for 2020, 2019 and 2018, respectively. Long-lived fixed assets located in the United States represented approximately 75% and 72% of the total long-lived fixed assets as of December 31, 2020 and 2019, respectively. The non-U.S. revenues and fixed assets are primarily related to UnitedHealthcare Global.

The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
2020								
Revenues — unaffiliated customers:								
Premiums	$ 191,679	$ 9,799	$ —	$ —	$ —	$ 9,799	$ —	$ 201,478
Products	—	33	135	33,977	—	34,145	—	34,145
Services	8,464	6,815	3,687	1,050	—	11,552	—	20,016
Total revenues — unaffiliated customers	200,143	16,647	3,822	35,027	—	55,496	—	255,639
Total revenues — affiliated customers	—	22,481	6,941	52,420	(1,800)	80,042	(80,042)	—
Investment and other income	732	680	39	51	—	770	—	1,502
Total revenues	$ 200,875	$ 39,808	$ 10,802	$ 87,498	$ (1,800)	$ 136,308	$ (80,042)	$ 257,141
Earnings from operations	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ —	$ 22,405
Interest expense	—	—	—	—	—	—	(1,663)	(1,663)
Earnings before income taxes	$ 12,359	$ 3,434	$ 2,725	$ 3,887	$ —	$ 10,046	$ (1,663)	$ 20,742
Total assets	$ 98,229	$ 52,073	$ 15,425	$ 39,280	$ —	$ 106,778	$ (7,718)	$ 197,289
Purchases of property, equipment and capitalized software	687	715	461	188	—	1,364	—	2,051
Depreciation and amortization	920	703	670	598	—	1,971	—	2,891
2019								
Revenues — unaffiliated customers:								
Premiums	$ 183,783	$ 5,916	$ —	$ —	$ —	$ 5,916	$ —	$ 189,699
Products	—	31	116	31,450	—	31,597	—	31,597
Services	8,922	5,732	3,630	689	—	10,051	—	18,973
Total revenues — unaffiliated customers	192,705	11,679	3,746	32,139	—	47,564	—	240,269
Total revenues — affiliated customers	—	17,966	6,239	42,093	(1,661)	64,637	(64,637)	—
Investment and other income	1,137	672	21	56	—	749	—	1,886
Total revenues	$ 193,842	$ 30,317	$ 10,006	$ 74,288	$ (1,661)	$ 112,950	$ (64,637)	$ 242,155
Earnings from operations	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ —	$ 19,685
Interest expense	—	—	—	—	—	—	(1,704)	(1,704)
Earnings before income taxes	$ 10,326	$ 2,963	$ 2,494	$ 3,902	$ —	$ 9,359	$ (1,704)	$ 17,981
Total assets	$ 88,250	$ 40,444	$ 15,181	$ 36,346	$ —	$ 91,971	$ (6,332)	$ 173,889
Purchases of property, equipment and capitalized software	841	573	495	162	—	1,230	—	2,071
Depreciation and amortization	926	565	672	557	—	1,794	—	2,720
2018								
Revenues — unaffiliated customers:								
Premiums	$ 174,282	$ 3,805	$ —	$ —	$ —	$ 3,805	$ —	$ 178,087
Products	—	52	111	29,438	—	29,601	—	29,601
Services	8,366	4,925	3,280	612	—	8,817	—	17,183
Total revenues — unaffiliated customers	182,648	8,782	3,391	30,050	—	42,223	—	224,871
Total revenues — affiliated customers	—	14,882	5,596	39,440	(1,409)	58,509	(58,509)	—
Investment and other income	828	481	21	46	—	548	—	1,376
Total revenues	$ 183,476	$ 24,145	$ 9,008	$ 69,536	$ (1,409)	$ 101,280	$ (58,509)	$ 226,247
Earnings from operations	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ —	$ 17,344
Interest expense	—	—	—	—	—	—	(1,400)	(1,400)
Earnings before income taxes	$ 9,113	$ 2,430	$ 2,243	$ 3,558	$ —	$ 8,231	$ (1,400)	$ 15,944
Total assets	$ 82,938	$ 29,837	$ 11,039	$ 33,912	$ —	$ 74,788	$ (5,505)	$ 152,221
Purchases of property, equipment and capitalized software	761	593	517	192	—	1,302	—	2,063
Depreciation and amortization	845	439	654	490	—	1,583	—	2,428

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) designed to provide reasonable assurance the information required to be disclosed by us in reports we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Annual Report on Form 10-K, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of December 31, 2020. Based upon their evaluation, our Chief Executive Officer and Chief Financial Officer concluded our disclosure controls and procedures were effective at the reasonable assurance level as of December 31, 2020.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2020 which have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Management on Internal Control Over Financial Reporting as of December 31, 2020

Management of UnitedHealth Group Incorporated and Subsidiaries (the Company) is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934. The Company's internal control system is designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. The Company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2020. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in Internal Control-Integrated Framework (2013). Based on our assessment and the COSO criteria, we believe that, as of December 31, 2020, the Company maintained effective internal control over financial reporting.

The Company's independent registered public accounting firm has audited the Company's internal control over financial reporting as of December 31, 2020, as stated in the Report of Independent Registered Public Accounting Firm, appearing under Item 9A.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of UnitedHealth Group Incorporated and subsidiaries (the "Company") as of December 31, 2020, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control—Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2020, of the Company and our report dated March 1, 2021, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Report of Management on Internal Control Over Financial Reporting as of December 31, 2020. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
March 1, 2021

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

DIRECTORS OF THE REGISTRANT

The following sets forth certain information regarding our directors as of March 1, 2021, including their name and principal occupation or employment:

Richard T. Burke
Lead Independent Director
UnitedHealth Group

Timothy P. Flynn
Retired Chair
KPMG International

Stephen J. Hemsley
Chair
UnitedHealth Group

Michele J. Hooper
President and Chief Executive Officer
The Directors' Council

F. William McNabb III
Former Chairman and Chief Executive Officer
The Vanguard Group, Inc.

Valerie Montgomery Rice, M.D.
President and Dean
Morehouse School of Medicine

John H. Noseworthy, M.D.
Former Chief Executive Officer and President
Mayo Clinic

Glenn M. Renwick
Former Chairman and Chief Executive Officer
The Progressive Corporation

Gail R. Wilensky, Ph.D.
Senior Fellow
Project HOPE

Andrew P. Witty
Chief Executive Officer
UnitedHealth Group

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401 of Regulation S-K, information regarding our executive officers is provided in Part I, Item 1 under the caption "Executive Officers of the Registrant."

We have adopted a code of ethics applicable to our principal executive officer and other senior financial officers, who include our principal financial officer, principal accounting officer, controller and persons performing similar functions. The code of ethics, entitled Code of Conduct: Our Principles of Ethics and Integrity, is posted on our website at www.unitedhealthgroup.com. For information about how to obtain the Code of Conduct, see Part I, Item 1, "Business." We intend to satisfy the SEC's disclosure requirements regarding amendments to, or waivers of, the code of ethics for our senior financial officers by posting such information on our website indicated above.

The remaining information required by Items 401, 405, 406 and 407(c)(3), (d)(4) and (d)(5) of Regulation S-K will be included under the headings "Corporate Governance" and "Proposal 1-Election of Directors" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Items 402 and 407(e)(4) and (e)(5) of Regulation S-K will be included under the headings "Executive Compensation," "Director Compensation," "Corporate Governance—Risk Oversight" and

"Compensation Committee Interlocks and Insider Participation" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS

The information required by section 201(d) and Item 403 of Regulation S-K will be included under the headings "Equity Compensation Plan Information" and "Security Ownership of Certain Beneficial Owners and Management" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Items 404 and 407(a) of Regulation S-K will be included under the headings "Certain Relationships and Transactions" and "Corporate Governance" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by Item 9(e) of Schedule 14A will be included under the heading "Disclosure of Fees Paid to Independent Registered Public Accounting Firm" in our definitive proxy statement for our 2021 Annual Meeting of Shareholders, and such required information is incorporated herein by reference.

PART IV

ITEM 15. EXHIBIT AND FINANCIAL STATEMENT SCHEDULES

(a) 1. *Financial Statements*

The financial statements are included under Item 8 of this report:

- Reports of Independent Registered Public Accounting Firm.
- Consolidated Balance Sheets as of December 31, 2020 and 2019.
- Consolidated Statements of Operations for the years ended December 31, 2020, 2019, and 2018.
- Consolidated Statements of Comprehensive Income for the years ended December 31, 2020, 2019, and 2018.
- Consolidated Statements of Changes in Equity for the years ended December 31, 2020, 2019, and 2018.
- Consolidated Statements of Cash Flows for the years ended December 31, 2020, 2019, and 2018.
- Notes to the Consolidated Financial Statements.

2. *Financial Statement Schedules*

The following financial statement schedule of the Company is included in Item 15(c):

- Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted.

(b) The following exhibits are filed or incorporated by reference herein in response to Item 601 of Regulation S-K. The Company files Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K pursuant to the Securities Exchange Act of 1934 under Commission File No. 1-10864.

EXHIBIT INDEX**

3.1	Certificate of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to UnitedHealth Group Incorporated's Registration Statement on Form 8-A/A, Commission File No. 1-10864, filed on July 1, 2015)
3.2	Amended and Restated Bylaws of UnitedHealth Group Incorporated, effective February 23, 2021 (incorporated by reference to Exhibit 3.2 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on February 26, 2021)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between the UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1988, amended as of November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to UnitedHealth Group Incorporated's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
4.5	Description of Common Stock (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.1	UnitedHealth Group 2020 Stock Incentive Plan (incorporated by UnitedHealth Group 2020 Stock Incentive Plan (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8, SEC File Number 333-238854, filed on June 1, 2020)
*10.2	Form of Agreement for Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)
*10.3	Form of Agreement for Nonqualified Stock Option Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)
*10.4	Form of Agreement for Performance-Based Restricted Stock Unit Award to Executives under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.4 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)

*10.5	Form of Agreement for Deferred Stock Unit Award to Non-Employee Directors under UnitedHealth Group Incorporated's 2020 Stock Incentive Plan (incorporated by reference to Exhibit 10.5 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020)
10.6	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Current Report on Form 8-K filed on July 1, 2015)
*10.7	Amended and Restated UnitedHealth Group Incorporated Executive Incentive Plan (2009 Statement), effective as of December 31, 2008 (incorporated by reference to Exhibit 10.12 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.8	Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan, effective as of December 31, 2008 (incorporated by reference to Exhibit 10.13 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.9	Amendment, dated as of December 21, 2012, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.11 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2012)
*10.10	Second Amendment, dated as of November 5, 2015, of Amended and Restated UnitedHealth Group Incorporated 2008 Executive Incentive Plan (incorporated by reference to Exhibit 10.3 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2015)
*10.11	UnitedHealth Group Executive Savings Plan (2021 Statement)
*10.12	Summary of Non-Management Director Compensation, effective as of September 1, 2020
*10.13	UnitedHealth Group Directors' Compensation Deferral Plan (2009 Statement) (incorporated by reference to Exhibit 10.18 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2008)
*10.14	Amendment to the UnitedHealth Group Directors' Compensation Deferral Plan, effective as of January 1, 2010 (incorporated by reference to Exhibit 10.20 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2009)
*10.15	First Amendment to UnitedHealth Group Directors' Compensation Deferral Plan (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010)
*10.16	Catamaran Corporation Third Amended and Restated Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.17	Catalyst Health Solutions, Inc. 2006 Stock Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Registration Statement on Form S-8, SEC File Number 333-205824, filed on July 23, 2015)
*10.18	Audax Health Solutions, Inc. 2010 Equity Incentive Plan, as amended (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 to Registration Statement on Form S-8, SEC File Number 333-205826, filed on February 15, 2017)
*10.19	Surgical Care Affiliates, Inc. 2016 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.3 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)

*10.20	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan (incorporated by reference to Exhibit 4.4 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.21	Surgical Care Affiliates, Inc. Management Equity Incentive Plan (incorporated by reference to Exhibit 4.5 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.22	Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan (incorporated by reference to Exhibit 4.6 to UnitedHealth Group Incorporated's Post-Effective Amendment No. 1 on Form S-8 to Registration Statement on Form S-4, SEC File Number 333-216153, filed on March 27, 2017)
*10.23	The Advisory Board Company Amended and Restated 2009 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on June 15, 2015)
*10.24	The Advisory Board Company 2005 Stock Incentive Plan (incorporated by reference to Exhibit 10.1 to The Advisory Board Company's Current Report on Form 8-K filed on November 17, 2005)
*10.25	Amended and Restated Employment Agreement, effective as of December 1, 2014, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015)
*10.26	Amendment to Employment Agreement, effective as of August 16, 2017, between United HealthCare Services, Inc. and David Wichmann (incorporated by reference to Exhibit 10.2 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017)
*10.27	Amended and Restated Employment Agreement, dated as of June 7, 2016, between United HealthCare Services, Inc. and John Rex (incorporated by reference to Exhibit 10.1 to UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016)
*10.28	Amended and Restated Employment Agreement, dated February 3, 2021 between the Company and Andrew P. Witty (incorporated by reference to Exhibit 5.02 to UnitedHealth Group Incorporated's Current Report on Form8-K filed on February 8, 2021)
*10.29	Amended and Restated Employment Agreement, effective as of March 16, 2015, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.44 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.30	Amendment to Employment Agreement, effective as of May 31, 2017, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.45 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.31	Amendment to Employment Agreement, effective as of March 12, 2019, between United HealthCare Services, Inc. and Dirk McMahon (incorporated by reference to Exhibit 10.46 to UnitedHealth Group Incorporated's Annual Report on Form 10-K for the year ended December 31, 2019)
*10.32	Employment Agreement, effective as of October 31, 2019, between United HealthCare Services, Inc. and Patricia Lewis
11.1	Statement regarding computation of per share earnings (incorporated by reference to the information contained under the heading "Net Earnings Per Common Share" in Note 2 of Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements")

21.1	Subsidiaries of UnitedHealth Group Incorporated
23.1	Consent of Independent Registered Public Accounting Firm
24.1	Power of Attorney
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS	XBRL Instance Document—the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	Inline XBRL Taxonomy Extension Schema Document.
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.
104	Cover Page Interactive Data File (formatted as Inline XBRL and embedded within Exhibit 101).

* Denotes management contracts and compensation plans in which certain directors and named executive officers participate and which are being filed pursuant to Item 601(b)(10)(iii)(A) of Regulation S-K.

** Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

(c) Financial Statement Schedule

Schedule I—Condensed Financial Information of Registrant (Parent Company Only).

Schedule I

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the shareholders and the Board of Directors of UnitedHealth Group Incorporated and Subsidiaries:

Opinion on the Financial Statement Schedule

We have audited the consolidated financial statements of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2020 and 2019, and for each of the three years in the period ended December 31, 2020, and the Company's internal control over financial reporting as of December 31, 2020, and have issued our reports thereon dated March 1, 2021; such reports are included elsewhere in this Form 10-K. Our audits also included the financial statement schedule of the Company listed in the Index at Item 15. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statement schedule based on our audits. In our opinion, the financial statement schedule, when considered in relation to the consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ DELOITTE & TOUCHE LLP

Minneapolis, Minnesota
March 1, 2021

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Balance Sheets

(in millions, except per share data)	December 31, 2020	December 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 258	$ 46
Other current assets	562	787
Total current assets	820	833
Equity in net assets of subsidiaries	107,714	93,467
Long-term notes receivable from subsidiaries	5,021	5,079
Other assets	342	794
Total assets	$ 113,897	$ 100,173
Liabilities and shareholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 589	$ 688
Current portion of notes payable to subsidiaries	4,882	750
Short-term borrowings and current maturities of long-term debt	4,465	3,548
Total current liabilities	9,936	4,986
Long-term debt, less current maturities	37,815	35,926
Long-term notes payable to subsidiaries	—	1,314
Other liabilities	655	331
Total liabilities	48,406	42,557
Commitments and contingencies (Note 4)		
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 946 and 948 issued and outstanding	10	9
Additional paid-in capital	—	7
Retained earnings	69,295	61,178
Accumulated other comprehensive loss	(3,814)	(3,578)
Total UnitedHealth Group shareholders' equity	65,491	57,616
Total liabilities and shareholders' equity	$ 113,897	$ 100,173

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Comprehensive Income

(in millions)	For the Years Ended December 31, 2020	2019	2018
Revenues:			
Investment and other income	$ 194	$ 209	$ 194
Total revenues	194	209	194
Operating costs:			
Operating costs	27	38	35
Interest expense	1,594	1,580	1,285
Total operating costs	1,621	1,618	1,320
Loss before income taxes	(1,427)	(1,409)	(1,126)
Benefit for income taxes	300	293	251
Loss of parent company	(1,127)	(1,116)	(875)
Equity in undistributed income of subsidiaries	16,530	14,955	12,861
Net earnings	15,403	13,839	11,986
Other comprehensive (loss) income	(236)	582	(1,517)
Comprehensive income	$ 15,167	$ 14,421	$ 10,469

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Condensed Statements of Cash Flows

(in millions)	For the Years Ended December 31, 2020	2019	2018
Operating activities			
Cash flows from operating activities	$8,842	$9,275	$6,099
Investing activities			
Issuances of notes to subsidiaries	(628)	(2,722)	(1,420)
Repayments of notes to subsidiaries	1,089	2,249	1,419
Cash paid for acquisitions	(7,706)	(9,645)	(4,066)
Return of capital to parent company	943	4,497	4,196
Capital contributions to subsidiaries	(43)	(803)	(1,259)
Other, net	143	490	4
Cash flows used for investing activities	(6,202)	(5,934)	(1,126)
Financing activities			
Common stock repurchases	(4,250)	(5,500)	(4,500)
Proceeds from common stock issuances	1,440	1,037	838
Cash dividends paid	(4,584)	(3,932)	(3,320)
Proceeds from (repayments of) short-term borrowings, net	872	300	(201)
Proceeds from issuance of long-term debt	4,864	5,444	6,935
Repayments of long-term debt	(3,150)	(1,750)	(2,600)
Proceeds (repayments) of notes from subsidiaries	2,818	1,207	(1,127)
Other, net	(438)	(535)	(923)
Cash flows used for financing activities	(2,428)	(3,729)	(4,898)
Increase (decrease) in cash and cash equivalents	212	(388)	75
Cash and cash equivalents, beginning of period	46	434	359
Cash and cash equivalents, end of period	$ 258	$ 46	$ 434
Supplemental cash flow disclosures			
Cash paid for interest	$1,633	$1,506	$1,294
Cash paid for income taxes	4,185	2,590	2,379

See Notes to the Condensed Financial Statements of Registrant

Schedule I

Condensed Financial Information of Registrant
(Parent Company Only)
UnitedHealth Group
Notes to Condensed Financial Statements

1. Basis of Presentation

UnitedHealth Group's parent company financial information has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this Form 10-K. The accounting policies for the registrant are the same as those described in Note 2 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

2. Subsidiary Transactions

Investment in Subsidiaries. UnitedHealth Group's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries.

Dividends and Capital Distributions. Cash dividends received from subsidiaries and included in Cash Flows from Operating Activities in the Condensed Statements of Cash Flows were $10.0 billion, $5.6 billion and $5.6 billion in 2020, 2019 and 2018, respectively. Additionally, $0.9 billion, $4.5 billion and $4.2 billion in cash were received as a return of capital to the parent company during 2020, 2019 and 2018, respectively.

3. Short-Term Borrowings and Long-Term Debt

Discussion of short-term borrowings and long-term debt can be found in Note 8 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements." Long-term debt obligations of the parent company do not include other financing obligations at subsidiaries which totaled $1.2 billion at December 31, 2020 and 2019.

Maturities of short-term borrowings and long-term debt for the years ending December 31 are as follows:

(in millions)	
2021	$ 4,446
2022	3,015
2023	2,125
2024	1,500
2025	2,300
Thereafter	29,177

UnitedHealth Group's parent company had notes payable to subsidiaries of $4.9 billion as of December 31, 2020, which included on-demand features.

4. Commitments and Contingencies

Certain regulated subsidiaries are guaranteed by UnitedHealth Group's parent company in the event of insolvency. UnitedHealth Group's parent company also provides guarantees related to its service level under certain contracts. None of the amounts accrued, paid or charged to income for service level guarantees were material as of December 31, 2020, 2019 or 2018.

For a summary of commitments and contingencies, see Note 12 of the Notes to the Consolidated Financial Statements included in Part II, Item 8, "Financial Statements."

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: March 1, 2021

UNITEDHEALTH GROUP INCORPORATED

By /s/ ANDREW P. WITTY

Andrew P. Witty
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ ANDREW P. WITTY **Andrew P. Witty**	Director and Chief Executive Officer (principal executive officer)	March 1, 2021
/s/ JOHN F. REX **John F. Rex**	Executive Vice President and Chief Financial Officer (principal financial officer)	March 1, 2021
/s/ THOMAS E. ROOS **Thomas E. Roos**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	March 1, 2021
* **Richard T. Burke**	Director	March 1, 2021
* **Timothy P. Flynn**	Director	March 1, 2021
* **Stephen J. Hemsley**	Director	March 1, 2021
* **Michele J. Hooper**	Director	March 1, 2021
* **F. William McNabb III**	Director	March 1, 2021
* **Valerie C. Montgomery Rice, M.D.**	Director	March 1, 2021
* **John H. Noseworthy, M.D.**	Director	March 1, 2021
* **Glenn M. Renwick**	Director	March 1, 2021
* **Gail R. Wilensky, Ph.D.**	Director	March 1, 2021

*By /s/ DANNETTE L. SMITH

Dannette L. Smith
As Attorney-in-Fact

Exhibit C: Proposal Compliance Matrix

RFP #:	3000017417
Proposer:	UnitedHealthcare of Louisiana, Inc.

RFP Section	Requirement	Proposal Section	Proposal Page(s)
2.4	Table of Contents		pg. i.
2.4.1	Cover Letter	2.4.1	pg. 1
Business Proposal – Section 2.5			
2.5.1	Mandatory Qualifications	2.5.1	pg. 1
2.5.2	Conflict of Interest	2.5.2	pg. 2
2.5.3	Moral or Religious Objections	2.5.3	pg. 2
2.5.4	Material Subcontractors	2.5.4	pg. 2
2.5.5	Financial Condition	2.5.5	pg. 3
2.5.6	Required Forms and Certifications:		
2.5.6.1	✓ Proposal Compliance Matrix	2.5.6	pg. 1
2.5.6.2	✓ Certification Statement	2.5.6	pg. 1
2.5.6.3	✓ Medicaid Ownership and Disclosure Form	2.5.6	Digital
Technical Proposal – Section 2.6			
2.6.2	Proposer Organization and Experience:		
2.6.2.1	✓ Proposer Organization	2.6.2	pg.5
2.6.2.2	✓ Proposed Staff Qualifications and Organizational Structure	2.6.2	pg.7
2.6.3	Enrollee Value-Added Benefits	2.6.3	pg.15
2.6.4	Population Health	2.6.4	pg. 28
2.6.5	Health Equity	2.6.5	pg.40
2.6.6	Care Management	2.6.6	pg.52
2.6.7	Case Scenarios	2.6.7	pg.67
2.6.8	Network Management	2.6.8	pg.109
2.6.9	Provider Support	2.6.9	pg.119
2.6.10	Utilization Management	2.6.10	pg.131
2.6.11	Quality	2.6.11	pg.146
2.6.11.6	Quality Response Template	2.6.11	Digital
2.6.12	Value-Based Payment	2.6.12	pg.161
2.6.13	Claims Management and Systems and Technical Requirements	2.6.13	pg.171
2.6.14	Program Integrity	2.6.14	pg. 205
2.6.15	Physical & Specialized Behavioral Health Integration Requirements	2.6.15	pg. 215
Veteran and Hudson Initiative Programs Participation – Sections 1.44 and 4.4			
4.4	Veteran and Hudson Initiatives Response	4.4	pg. 225

EXHIBIT A: CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. The Proposer should identify the Contact name and fill in the information below: (Print Clearly)

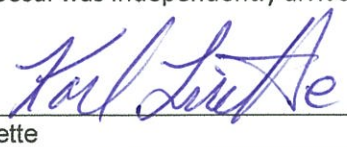
Official Contact Name:	Karl Lirette
E-mail Address:	karl.lirette@uhc.com
Facsimile Number with area code:	855-609-2684
US Mail Address:	3838 N Causeway Blvd, Suite 2500, Metairie, LA 70002

Proposer shall certify that the above information is true and shall grant permission to the State or Agencies to contact the above named person or otherwise verify the information provided.

By its submission of this proposal and authorized signature below, Proposer shall certify that:

1. The information contained in its response to this RFP is accurate and all copies are correct and complete.
2. Proposer shall comply with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein.
3. Proposer shall accept the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer agrees to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to the Proposer's financial, legal, contractual, or other business interests as they relate to the RFP and contract.
5. Proposer does not have any financial, legal, contractual, and other business interest that will conflict in any manner or degree with the performance required under the contract.
6. Proposer does not have, nor does any of the Proposer's Material Subcontractors have, any financial, legal, contractual or other business interest in LDH's Enrollment Broker or in such vendor's subcontractors, if any.
7. Proposer acknowledges it will not be relieved of any legal obligations under any contract resulting from this RFP as a result of any contracts with subcontractors, that it shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the contract.
8. Proposer acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.
9. Unless provided for in the contract, the Proposer shall not contract with any other party for any of the services provided for therein without the express prior written approval of the Department
10. Proposal shall be valid for at least ninety (90) Calendar Days from the date of proposer's signature below.

11. Proposer understands that if selected as the successful Proposer, he/she will have twenty (20) Calendar Days in which to complete contract negotiations and twenty (20) Calendar Days from the date of delivery of final contract in which to execute the final contract document.
12. Proposer shall certify, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in 2 CFR §200 Subpart F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov.)
13. Proposer understands that, if selected as a contractor, the Louisiana Department of Revenue must determine that it is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the LDR. Proposer shall comply with La. R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.
14. Proposer further acknowledges its understanding that issuance of a tax clearance certificate by LDR is a necessary precondition to the approval of any contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to any contract without penalty and proceed with alternate arrangements, should a prospective contractor fail to resolve any identified outstanding tax compliance discrepancies with the LDR within seven (7) days of such notification.
15. Proposer certifies and agrees that the following information is correct: In preparing its response, the Proposer has considered all proposals submitted from qualified, potential subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any subcontractor or supplier, refused to transact or terminated business activities, or taken other actions intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or other entity for reporting such refusal, termination, or commercially limiting actions. The State reserves the right to reject the response of the Proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.
16. Proposer certifies that its proposal was independently arrived at without collusion.

Signature of Proposer or Authorized Representative:	
Typed or Printed Name:	Karl Lirette
Date:	September 3, 2021
Title:	Chief Executive Officer
Company Name:	UnitedHealthcare Community Plan/ Vendor Number: 310097820
Address:	3838 N. Causeway Blvd. Suite 2500
City:	Metairie
State:	Louisiana
Zip:	70002

Instructions for Louisiana Medicaid Ownership Disclosure Information Entity/Business

This is a multi-page form. Please review the instructions in their entirety before completing the form. ***Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.***

Refer to the web sites listed on the previous pages for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Enter your Provider Name at the top of each page in the space provided.

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.

Taxpayer ID Number – Enter the nine (9) digit Tax ID number for this provider.

National Provider Identifier (NPI) – Enter your ten (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov

This enrollment packet is for a – Check the appropriate box from among New Enrollment, Update to Current Enrollment, Re-Validation, Re-Enrollment or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.

Provider Type – Enter the Louisiana Medicaid Provider Type for this Entity/Business.

Primary Telephone Number(s) of Disclosing Entity/Business - Enter the area code and telephone number(s) at the street address of this Entity/Business.

Doing Business As (DBA) Name – Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the Entity/Business license.

Legal Name of Disclosing Entity/Business – Enter the legal name of the Entity/Business in the space labeled "Legal Name of Entity/Business."

Primary Disclosing Entity/Business Street Address, City, State, Zip - Enter the physical business street address of the Entity/Business requesting enrollment. Enter the city, state and zip code of the physical business street address.

Primary Disclosing Entity/Business Mailing Address/PO Box, City, State, Zip – Enter the mailing address or PO Box of the Entity/Business requesting enrollment. Enter the city, state and zip code of the mailing address.

Additional Post Office Boxes Not Identified Above – Enter any additional Post Office Boxes for the Entity/Business that are stand-alone or not associated with any business location.

Disclosing Entity/Business Telephone Number to Request Medical Records – Enter the area code and telephone number(s) that the Entity/Business uses to answer requests for medical records.

Disclosing Entity/Business Primary Fax Number – Enter the area code and fax number(s) of this Entity/Business.

Email Address of Entity/Business contact person - Enter the email address of the contact person who should receive official LDH notices.

Entity/Business Website – Enter the web address of the Entity/Business website if applicable.

A. **Is there a Corporate Office location for the disclosing Entity/Business?** Check the appropriate box.
DBA Name of Corporate Office – If the Entity/Business does have a corporate office location, enter the DBA Name of that office.
Corporate Office contact information – Enter the street address, mailing address/PO Box, additional PO boxes, phone number, fax number and email address for the corporate office.

B. **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below. Lists are not acceptable.
DBA Name of Additional Location – Enter the DBA name of the additional practice location.
Medicaid Provider # - Enter the Medicaid Provider number of the additional practice, if applicable.
Additional Location contact information – Enter the mailing address/PO Box, street address, additional PO boxes, phone number, fax number and email address for the additional location office. Continue identifying additional locations and the contact information in the spaces provided. If needed, please attach additional sheets if there are more than three additional locations.

C. **Identify how this disclosing Entity/Business is registered with the Internal Revenue Service – Select only 1 of the categories.** Multiple selections may result in a rejection for clarification.
Privately owned or Non-profit Providers Only – Identify the type of Entity/Business as it is registered with the Internal Revenue Service (IRS). Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of Entity/Business in the space(s) provided. Optional: May add comments in the space provided. Continue to Section II.
OR
Louisiana Government Providers Only – Identify the type of Entity/Business if Louisiana government owned. Select only one from among City and/or Parish, Department of Children and Family Services (DCFS), Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Villa, Other LDH agency, Local Education Agency (LEA), Louisiana State University (LSU), or Other State-owned entity. Check the appropriate box and complete the applicable fields.

D. **Is this disclosing Entity/Business publicly traded?** A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check the appropriate box.

E. **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?** Check the appropriate box. If yes, list all names and Tax IDs in the spaces provided. Attach additional pages if needed.

SECTION II – ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A. **Has this Entity/Business (since its existence) AND any entity/business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, 1) provide a written statement including the details on all occurrences and 2) attach all official legal documents, including any reinstatements.

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the Entity/Business address, Entity/Business telephone number, and the Entity/Business email address of the person completing this form. Finally, enter any additional Entity/Business telephone number(s) and Entity/Business email address(es).

SECTION V – OWNERSHIP INFORMATION

Medicaid requires that an Entity/Business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this Entity/Business. A separate form, Section V(b), is required for each owner, therefore, please make the necessary copies as a list of owners will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Owners are individuals and/or organizations having direct, indirect, or controlling ownership interest in this disclosing Entity/Business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing Entity/Business.
- Indirect ownership is defined as an ownership interest in an Entity/Business that has direct or indirect ownership in this disclosing Entity/Business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the Entity/Business.
    - To dissolve or transfer this disclosing Entity/Business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the Entity/Business:

- Whose personal assets are used to satisfy the Entity/Business creditors.
- Who join together to carry on an Entity/Business and expect to share in the profits and losses of the Entity/Business.
- Who report their share of profits and losses of the Entity/Business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION V(a) – INFORMATION ON ALL OWNERS

NEW FORMAT! Please read these directions in detail.

A. **Individuals & Entities/Businesses with Direct Ownership** –List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/ or controlling interest of 5% or greater in the disclosing Entity/Business. Add additional pages if needed.
NOTE: Section V(b) must be completed for each individual listed. Item B and Section V(c) must be completed for each entity/business listed.

B. **Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business** –
First column: List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business in the first column. The disclosing Entity/Business cannot list itself as an owner.
Second column: Name all owners of the entity/business listed in the first column.
Third column: Indicate the percent of ownership each owner has in the entity/business in the first column.
Fourth column: Indicate the percent ownership each owner has in the disclosing Entity/Business. This percent of indirect ownership in the disclosing Entity/Business is determined by multiplying the percentages of ownership in e

ach entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.
Add additional pages if needed.
NOTE: Section V(c) must be completed for each Entity/Business listed and Section V(b) must be completed for each individual listed.

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for **each and every individual owner named in Section V(a)**, whether the individual owns a direct or indirect stake in the disclosing Entity/Business. A list of all owners will not be accepted. **Make a copy of the blank form for each owner you report before you fill it out the first time.** For example, if you have five owners, you need to submit five completed Section V(b) forms.

A. **Individual Owner Information** – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this Entity/Business, the percentage of ownership of the Entity/Business, the Social Security Number (required), date of birth, current mailing address and physical address, telephone number and email address of the owner in the spaces provided.

B. **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?** – Read the question carefully and check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this owner a U.S. citizen?** Check the appropriate box. If no, provide the Alien Verification number.

D. **Does this owner reside outside the State of Louisiana?** – Check the appropriate box. If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the appropriate box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided. Attach additional pages if needed.

E. **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related (e.g. spouse, parent, child, sibling) in the spaces provided. Attach additional pages if needed.

F. **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

G. **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business participating in a Federal/State funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

H. **Has the individual owner named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. **Entity/Business Owner Information** – Enter the Entity/Business Name, the DBA Name, the Tax ID Number, the current street address of the primary location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided.

B. **Are there any business locations in addition to the location listed above?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location. Enter the DBA Name of the additional location, the Tax ID Number, the current street address of the additional location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided. Attach additional pages if needed.

C. **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?** Check the appropriate box. If yes, list all names and Tax IDs below. Attach additional pages if needed.

D. **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

E. **Is this Entity/Business and Tax ID listed in the Section I currently enrolled in a Federal/State funded healthcare program?** If yes, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments.

F. **Has this Entity/Business (since its existence) AND any Entity/Business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with, since the inception of those programs, as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, provide a written statement including the details on all occurrences. Attach all official legal documents, including any reinstatements.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

A separate VI(b) form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or manager control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

In the first table, enter the names of each agent, member or officer who is a part of management for the disclosing Entity/Business. In the second table, enter the names of each managing employee for the disclosing Entity/Business. Select the appropriate box to indicate if the individual is also an owner. If so, list their percentage of ownership. Add additional pages if needed.

NOTE: Section VI(b) must be completed for each individual listed unless individual has already been reported in Section V.

SECTION VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Make a photocopy of Section VI(b) for each managing employee/agent you report.

A. **AGENT– or – MANAGING EMPLOYEE –** Check a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, current physical address, telephone number and email address in the spaces provided.

B. **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? –** Check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. **Is this agent or managing employee a U.S. citizen?** Check the appropriate box. If no, provide Alien Verification number.

D. **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

E. **Has the agent or managing employee named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

F. **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION VII – AUTHORIZED REPRESENTATIVES

List the individuals who are authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms. Every person listed here must be either an owner or a managing employee as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a managing employee, or other (specify the title in the space provided).

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.
Title/Position of Authorized Representative – indicate the Authorized Representative's relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).
Signature of Authorized Representative – the authorized representative must sign the form. Signatures must be original and in blue ink (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.
Date of Signature – enter the date this agreement was signed.

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date. Please sign in colored ink (not black).

Reference Material for Louisiana Medicaid Ownership Disclosure Information
For an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:** http://url.ie/ywri

MAPIL Louisiana R.S., Title 46:437.1-14. http://url.ie/yw45

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://url.ie/yw46

Louisiana Update January/February 2009: http://url.ie/yw47

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://tinyurl.com/ne58pwb

Social Security Act 1128 a: http://tinyurl.com/3lnj2z9

Provider Name: _____

CONFIDENTIAL

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number (Leave blank if applying for new number)	2	3	7	6	9	8	5

Taxpayer ID Number	7	2	1	0	7	4	0	0	8

National Provider Identifier (NPI)	1	9	0	2	3	6	9	3	1	7

This enrollment packet is for a ☐ New Enrollment ■ Update to Current Enrollment ☐ Re-Validation ☐ Re-Enrollment	☐ Change of Ownership (CHOW) _____ (Date of CHOW) _____ (Current Medicaid Provider Number)
Provider Type: Not applicable	Primary Telephone Number of Disclosing Entity/Business ( )

Doing Business As (DBA) Name UnitedHealthcare Community Plan	Legal Name of Disclosing Entity/Business UnitedHealthcare of Louisiana, Inc.		
Primary Disclosing Entity/Business Street Address 3838 N. Causeway Blvd., Suite 2500	City Metairie	State LA	Zip 70002
Primary Disclosing Entity/Business Mailing Address/PO Box 3838 N. Causeway Blvd., Suite 2500	City Metairie	State LA	Zip 70002
Additional Post Office Boxes Not Identified Above N/A	City	State	Zip
Disclosing Entity/Business Telephone number to request medical records ( )	Disclosing Entity/Business Primary Fax Number ( )		
Email Address of Entity/Business contact person LA_UHC_CP@uhc.com	Entity/Business Website (if applicable) www.uhccommunityplan. com		

A. ☐ **Yes** ■ **No** **Is there a Corporate Office location separate from the primary location of the disclosing Entity/Business?**

If yes, complete the section below.

DBA Name of Corporate Office			
Corporate Office Street Address	City	State	Zip
Corporate Office Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Corporate Office Phone Number ( ) -	Corporate Office Fax Number ( ) -		
Corporate Office Email address			

Provider Name: _____

CONFIDENTIAL

Make a photocopy of this page if more space is needed to list additional locations

B. ☒ **Yes** ☐ **No** **Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services?** Lists are not acceptable.

1 If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Medicaid Provider #, if applicable		
UnitedHealthcare Community Plan			
Additional Location Street Address	City	State	Zip
8550 United Plaza Blvd., Suite 703	Baton Rouge	LA	70809
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State	Zip
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

Provider Name: _____

CONFIDENTIAL

Make a photocopy of this page if more space is needed to respond to item E below

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service

Select only one (1) – multiple selections may result in a rejection for clarification

Privately Owned or Non-profit Providers Only

☐ **Sole Proprietorship**

☐ **Partnership/Limited Liability Partnership**: How many members are identified with this partnership? _____

☒ **Corporation:** Revenue greater than or equal to $5M annually Yes Revenue less than $5M annually _____

In the (current) Articles of Incorporation: How many stakeholders/individual owners are identified? 1

How many Board of Director members are identified? _____

How many officers are identified? 10

☐ **Limited Liability Corporation (LLC)**
In the (current) Articles of Organization: How many members are identified? _____

How many managing employees are identified? _____

☐ **Non-profit:** How many members are appointed to the governing board? _____ (Must attach IRS verification showing the non-profit status)

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**

☐ **DCFS**

☐ **LDH**
☐ OBH ☐ OPH
☐ OAAS ☐ OCDD
☐ Villa ☐ Other _____

☐ **LEA (Local Education Agency)**

☐ **LSU**
Hospital -_____

☐ **Other State-owned entity:** _____

D. ☐ **Yes** ☒ **No** **Is this disclosing Entity/Business publicly traded? See instructions.**

E. ☒ **Yes** ☐ **No** **Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name Southeast Health Plan of Louisiana, Inc.	Tax ID (no change in Tax ID)
Name Community Health Network of Louisiana	Tax ID (no change in Tax ID)
Name	Tax ID
Name	Tax ID
Name	Tax ID

Provider Name: _____

CONFIDENTIAL

SECTION II – DISCLOSING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

A. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows:

☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

CONFIDENTIAL

Make a photocopy of this page if more space is needed to respond to item A below

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. ☒ **Yes** ☐ **No** **Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, provide the details in the fields below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
Medicaid	UnitedHealthcare Community Plan	72-1074008	LA	2376985

SECTION IV - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Karl	Anthony		Lirette		

Social Security Number	Date of Birth	Job Title
	05/05/1970	Health Plan Chief Executive Officer

The person completing this form is (please check one):

☒ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip
3838 N Causeway Blvd 2500	Metairie	LA	70002

Entity/Business Telephone Number	Entity/Business Email Address
	LA_UHC_CP@uhc.com
Additional Entity/Business Telephone Number(s)	**Additional Entity/Business Email Address(es)**
	N/A

Provider Name: _____ **CONFIDENTIAL**

NEW FORMAT! PLEASE REFER TO THE INSTRUCTIONS FOR DETAILED EXPLANTIONS!

Make a photocopy of this page if more space is needed to list owners in items A and B

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals & Entities/Businesses with Direct Ownership

List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/or controlling interest of 5% or greater in the disclosing Entity/Business.

*Fill out Section V(b) for each **Individual**. Fill out both item B and Section V(c) for each **Entity/Business** listed below.*

Individuals or Entities/Businesses with ownership	% of ownership
1. UnitedHealthcare, Inc.	100
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business

List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business. Identify the owners of that Entity/Business and their % of ownership below.* The disclosing Entity/Business cannot be listed as an owner.

*Fill out Section V(b) for each **Individual** and Section V(c) for each **Entity/Business** listed below.*

Entity/Business/Organization with a direct ownership interest listed in item A	Owners of the Entity/Business identified on the left.	% of ownership in Entity/Business identified on the left	% of ownership in the disclosing Entity/Business
1. N/A	a.		
	b.		
	c.		
	d.		
2.	a.		
	b.		
	c.		
	d.		
3.	a.		
	b.		
	c.		
	d.		
4.	a.		
	b.		
	c.		
	d.		
5.	a.		
	b.		
	c.		
	d.		

*The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

Provider Name: ____ **CONFIDENTIAL**

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
N/A					

Title/Job Position within the disclosing Entity/Business	% ownership	Social Security Number (required)	Date of Birth
		- -	

Healthcare NPI (if applicable)

Street Address	City	State	Zip Code
Mailing Address/PO Box	**City**	**State**	**Zip Code**

Telephone Number	Email address
- -	

B. ☐ Yes ☐ No **Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☐ Yes ☐ No **Is this owner a U.S. citizen? If no, provide Alien Verification** ____________________________

D. ☐ Yes ☐ No **Does this owner reside outside the State of Louisiana?**

☐ Yes ☐ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?
If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

E. ☐ Yes ☐ No **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title:

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to items F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: N/A

F. ☐ **Yes** ☐ **No** **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

G. ☐ **Yes** ☐ **No** **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: N/A

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
H. Has the individual owner named above (ever):	
☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name: N/A	Legal Name of Entity/Business: UnitedHealthcare, Inc.	Tax ID Number (required): 41-1922511		
Entity/Business Street Address – Primary Location: 9800 Health Care Lane	City: Minnetonka	State: MN	Zip: 55343-4522	
Entity/Business Mailing Address/PO Box: 9800 Health Care Lane	City: Minnetonka	State: MN	Zip: 55343-4522	
Additional Post Office Boxes Not Identified Above: N/A	City	State	Zip	
Telephone Number: (952) 936-1709 -	Fax Number: ( ) -			
Email address of Entity/Business contact person: N/A	Entity/Business Website (if applicable)			

B. ☐ **Yes** ☒ **No** **Are there any business locations in addition to the location listed above?**

If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number: ( ) -	Additional Location Fax Number: ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Tax ID Number		
Additional Location Mailing Address/PO Box	City	State	Zip
Additional Location Street Address	City	State	Zip
Additional Post Office Boxes Not Identified Above	City	State	Zip
Additional Location Phone Number: ( ) -	Additional Location Fax Number: ( ) -		
Additional Location Email address			

C. ☐ **Yes** ☒ **No** **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: _____

CONFIDENTIAL

Make a photocopy of this page if more space is needed to respond to item E below

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: UnitedHealthcare, Inc.

D. ☐ **Yes** ■ **No** **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State	Zip Code
Telephone Number - -	Email address		

E. ■ **Yes** ☐ **No** **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#
UnitedHealthcare of Louisiana, Inc.	UnitedHealthcare Community Plan	72-1074008	LA	2376985

Provider Name: _____

CONFIDENTIAL

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: UnitedHealthcare, Inc.

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks. **F. Has this Entity/Business (since its existence) – AND –** **Any Entity/Business affiliated with the same Tax ID number – AND –** **Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:**	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
■ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1. Peter Marshall Gill	☐ Yes ■ No	
2. John Jospeh Matthews	☐ Yes ■ No	
3. Heather Anastasia Lang	☐ Yes ■ No	
4. Jessica Leigh Zuba	☐ Yes ■ No	
5. Nyle Brent Cottington	☐ Yes ■ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing employee(s)	Is this managing employee also an owner?	% ownership
1. Warren Paul Murrell III - Chairman of the Board & Health Plan CEO	☐ Yes ■ No	
2. Karl A. Lirette - President & Health Plan Chief Medical Officer	☐ Yes ■ No	
3. Angela Olden - Chief Operations Officer	☐ Yes ■ No	
4. Julie C. Morial - Chief Medical Officer	☐ Yes ■ No	
5. Collin McQuiddy Chief Financial Officer	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Peter	Marshall		Gill		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Treasurer		[redacted]	[redacted] /

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address	**City**	**State**	**Zip Code**
[redacted]			

Telephone Number	Email address
[redacted]	[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Peter M. Gill

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
John	Joseph		Matthews		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Secretary		[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address Same	City	State	Zip Code

Telephone Number	Email address
[redacted]	[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: John J. Matthews

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Heather	Anastasia		Lang		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Assistant Secretaty		[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address Same	City	State	Zip Code
Telephone Number [redacted]	Email address [redacted]		

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Heather A. Lang

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Jessica	Leigh	Ems	Zuba		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Assistant Secretary		[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address Same	City	State	Zip Code

Telephone Number	Email address
[redacted]	[redacted]

B. ☒ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Jessica	Leigh	Ems			
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Jessica L. Zuba

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Nyle	Brent		Cottington		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Vice President		[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address Same	City	State	Zip Code

Telephone Number	Email address
[redacted]	[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Nyle Brent Cottington

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☒ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Warren	Paul		Murrell	-	III

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chairman of the Board		[redacted]	[redacted] /

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address Same	City	State	Zip Code

Telephone Number	Email address
[redacted]	[redacted]

B. ☐ Yes ☒ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
				-	

C. ☒ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ☒ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Warren Paul Murrell III

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Karl	Anthony		Lirette		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
CEO UnitedHealthcare Community Plan, Louisiana	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address same	**City** same	**State** same	**Zip Code** same
Telephone Number [redacted] -	**Email address** [redacted]		

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Karl Lirette

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ☐ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Angela	Sue	Hoskins	Olden		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
COO-UnitedHealthcare Community Plan, Louisiana	-0-	[redacted]	[redacted]

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address same	**City**	**State**	**Zip Code**
	[redacted]	[redacted]	[redacted]

Telephone Number	Email address
[redacted] -	[redacted]

B. ■ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Angela	Sue	Hoskins	Olden		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Angela Olden

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ **Yes** ■ **No** **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?**

If yes, complete the section below.

Plan	**Doing Business As (DBA) Name**	**Tax ID**	**Plan Numbers for Enrollments**	
			State	**ID#**

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Collin	Stewart		McQuiddy		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
CFO-UnitedHealthcare Community Plan, Louisiana	-0-	[redacted]	[redacted] /

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address	**City**	**State**	**Zip Code**
same	same	same	same
Telephone Number	**Email address**		
[redacted] -	[redacted]		

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Collin McQuiddy

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

CONFIDENTIAL

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ AGENT– or – ■ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Julie	Claire		Morial		

Title/Job Position within this Entity/Business	% ownership	Social Security Number (required)	Date of Birth
Chief Medical Officer-UnitedHealthcare Community Plan, Louisiana	-0-	[redacted]	[redacted] /

Mailing Address/PO Box	City	State	Zip Code
[redacted]	[redacted]	[redacted]	[redacted]
Physical Address	**City**	**State**	**Zip Code**
same	same	same	same

Telephone Number	Email address
- -	

B. ☐ Yes ■ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

C. ■ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

D. ☐ Yes ■ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

CONFIDENTIAL

** Make a photocopy of this page if more space is needed to respond to item F below**

Name of Agent or Managing Employee: Julie C. Morial, MD

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
E. Has the agent or managing employee named above (ever):	
☐ Yes ■ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ■ No	Has any disciplinary action been taken against any healthcare license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ■ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ■ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ■ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time.
☐ Yes ■ No	Currently have any open or pending healthcare court cases?
☐ Yes ■ No	Been denied malpractice insurance?
☐ Yes ■ No	Has or had a felony conviction(s) of any type?

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ■ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1. Karl A. Lirette, Chief Executive Officer	☐ Owner ■ Managing employee ☐ Other _____
2.	☐ Owner ☐ Managing employee ☐ Other _____
3.	☐ Owner ☐ Managing employee ☐ Other _____
4.	☐ Owner ☐ Managing employee ☐ Other _____
5.	☐ Owner ☐ Managing employee ☐ Other _____
6.	☐ Owner ☐ Managing employee ☐ Other _____
7.	☐ Owner ☐ Managing employee ☐ Other _____
8.	☐ Owner ☐ Managing employee ☐ Other _____
9.	☐ Owner ☐ Managing employee ☐ Other _____
10.	☐ Owner ☐ Managing employee ☐ Other _____

Please sign in blue ink (not black)

Karl A. Lirette
Printed Name of Authorized Representative

Karl Lirette
Signature of Authorized Representative
(sign in blue ink)

Chief Executive Officer
Title/Position

8/26/21
Date of Signature

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Karl A. Lirette
Printed Name of Authorized Representative

Karl Lirette
Signature of Authorized Representative
(sign in blue ink)

Health plan CEO
Title/Position of Authorized Representative

8/26/21
Date of Signature

Exhibit D – Written Litigation Statement

CONFIDENTIAL

Formal Matter Name/Caption	Matter Status	Open Date	Forum	Venue	Docket/Reference Number	Matter description
[redacted]						

CONFIDENTIAL

Formal Matter Name/Caption	Matter Status	Open Date	Forum	Venue	Docket/Reference Number	Matter Description
[redacted]						

2.6.2 Proposer Organization and Experience

2.6.2.1 Proposer Organization [2-page limit; information related to non-compliance actions are exempt from …
2.6.2.1.1 The Proposer should provide a brief summary of the organizational history of the Proposer and, where …
2.6.2.1.2 The Proposer shall identify whether the Proposer, and/or its parent organization, and its affiliate …
2.6.2.1.3 Proposer shall identify and describe any instances of non-compliance which the Proposer, and/or its …
2.6.2.1.4 Proposer shall provide a brief statement if any of the following has occurred: Within the last ten (10) …

Organizational History

UnitedHealthcare is privileged to have served in a nine-year partnership with the residents of Louisiana and the Louisiana Department of Health (LDH). As of August 2021, we serve more than 500,000 Louisiana enrollees. 2019 **NCQA rates UnitedHealthcare as Louisiana's top-quality Medicaid plan.** Through our commitment to enrollee health, strong brand recognition and community-based partnerships, we are the **enrollees' MCO of choice** for the past eight years, with the highest member **proactive choice rate and a 2020 choice rate of 75.1%.**

Organizational Goals

Our goals for Louisiana's health care delivery system fully align with the goals set forth by LDH. These goals are specifically designed for Louisiana enrollees, providers and communities and are grounded in five strategic pillars. These pillars are to:

- Achieve operational excellence
- Advance health equity
- Elevate integrated care
- Evolve local engagement
- Support provider transformation

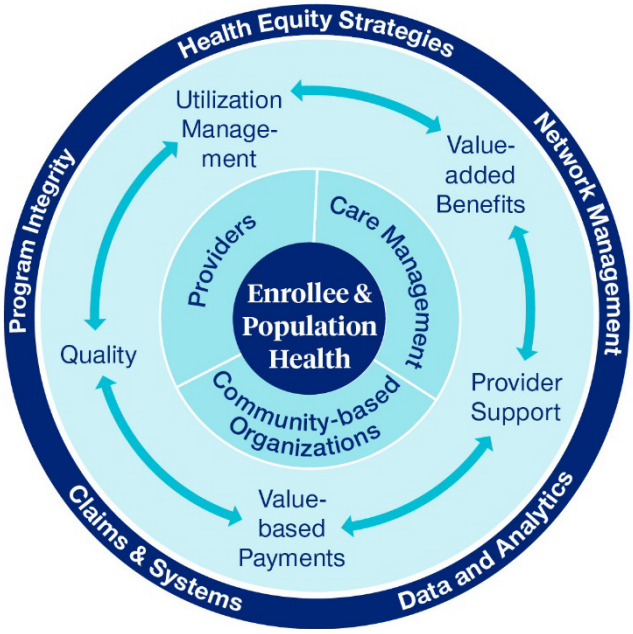


Figure 1. Illustrates the critical elements addressed to meet our organizational goals, which improve enrollee and population health and provide whole-person care to Louisiana enrollees.

Figure 1 illustrates our approach to our goals and how we navigate the complex health care eco-system for the success of our enrollees. To improve enrollee and population health, we rely on our network of behavioral and medical providers, our care management system and our partnership with community-based organizations (CBOs) to provide whole-person care, including addressing social determinants of health. We are mindful that everything we do through Utilization Management (UM), Value-Adds, Value-Based Payment (VBP), Provider Support and Quality is interconnected. Our ability to act as a reliable and consistent partner is critical to the success of our providers, case managers and CBOs. The outer circle calls out elements of the entire delivery system we also engage. Health equity and program integrity must be integrated with all efforts that support our enrollees, and none of it is possible without comprehensive network relationships, timely claims payments, and solid data and analytics to measure our progress.

Relevance of Medicaid Managed Care to Our Mission

Our mission drives us to help make the health care system work better for everyone, and our commitment to Medicaid managed care allows us to address the systemic barriers, whether those be based upon access, chronic illness burden, health disparities or lack of personal resources faced by many Medicaid eligible individuals. For our managed Medicaid enrollees, this mission is more important than ever, therefore, we consistently bring innovations and creativity to this population to fulfill our mission and help them live healthier lives.

Volume and States of Our Medicaid Managed Care Business

UnitedHealthcare has provided Medicaid managed care and public sector services for 47 years. We serve 7,160,000 low-income and medically fragile members, including D-SNP members, in 31 states plus the District of Columbia. These states include Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Mississippi, North Carolina, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Washington and Wisconsin (plus the District of Columbia).

UnitedHealthcare has partnered with the residents of Louisiana and the LDH for over nine years. As of July 30, 2021, we serve more than 500,000 Louisiana enrollees and are the largest organically grown MCO in the State. Our nine years of Louisiana MCO experience comprise six years of Medicaid managed care Full Risk MCO experience in addition to three years of Shared Savings MCO experience. We first contracted with LDH in February 2012.

Within the last 12 months, UnitedHealthcare has engaged in or been awarded new contracts in 27 states. We contract with 15 states that have a Medicaid population equal to or greater than 1.5 million enrollees. These states include California, New York, Texas, Florida, Ohio, Pennsylvania, Michigan, New Jersey, Arizona, Washington, Louisiana, North Carolina, Tennessee, Indiana and Kentucky. A few examples of these contracts include:

- Tennessee: Our contract for the Tennessee TennCare Medicaid program started January 2014 and runs through December 2022, serving more than 487,210 enrollees as of May 2021. We serve LTSS, SSI, TANF, ABD and uninsured children populations in Tennessee. This integrated system joins physical and behavioral health services.
- North Carolina: Our North Carolina Health Choices Program contract started July 2021 and runs through June 2024. We serve more than 360,000 enrollees through TANF, CHIP, ABD and non-dual LTSS populations. North Carolina's program design seeks to advance high-value care, improve population health, and engage and support providers.
- Texas: Our contracts for Texas STAR Medicaid, Texas CHIP, Texas STAR+PLUS and STAR Kids programs started June 2021 and run through August 2022. We serve 375,105 enrollees (as of March 2021). We serve ABD, SSI, SSI-related seniors, LTC beneficiaries, TANF, CHIP, children and youth with disabilities and LTSS populations in Texas. All of the Texas programs mentioned above integrate physical and behavioral health.

The tables in Attachment 2.6.2.1.3. RFP Non-Compliance describes UnitedHealthcare's instances of non-compliance with our Medicaid managed care contracts within the past seven years.

UnitedHealthcare of Louisiana, Inc., the bidding entity, has not had any Medicaid managed care contracts terminated or not renewed for any reason within the past 10 years.

Att. 2.6.2.1.3 RFP Non-Compliance

2.6.2.2 Proposed Staff Qualifications and Organizational Structure [6-page limit; organizational chart and resumes…
2.6.2.2.1 The Proposer should describe its process for identifying its key personnel and describe its management …

At UnitedHealthcare, we are dedicated to building diverse and inclusive teams where every individual is recognized for their experience and contributions. Our candidates possess exceptional qualifications for each position supporting our Louisiana enrollees. To the greatest extent possible, we seek individuals who are local to Louisiana and represent the populations we serve. Nearly 45% of our Medicaid enrollees in Louisiana are people of color. [redacted] Candidates will have extensive experience working with diverse populations, including people of all abilities. Our current leadership team comprises experts in the management of large health care delivery enterprises, including leadership in managed care systems, Medicaid programs and operations. [redacted] Our Louisiana team reports to the UnitedHealthcare Community Plan leadership and Executive Committee in Louisiana, which reports to the national UnitedHealthcare Community & State executive leadership. The national executive leadership provides direction and sets policies for UnitedHealthcare Medicaid programs nationwide and is accountable to the board of directors of UnitedHealthcare Insurance Company. The local Louisiana executive team develops the long-term strategy, business plans and provides daily management, while administering and managing the Medicaid managed care program. The Louisiana leadership team and staff oversee local outreach and education, health and social services delivery, care management, network management, quality management, provider services and compliance functions.

2.6.2.2.2 For each individual appointed to a key personnel role, the Proposer should provide the individual's name…

Our key personnel are listed below. Resumes have been included as Attachment 2.6.2.2.2. Organizational charts are embedded in our narrative and total two pages

Karl Lirette, Chief Executive Officer: Mr. Lirette has full binding authority and autonomy over the operational management of the Medicaid program and remains fully accountable to the Department for every aspect of program administration. A lifelong resident of Louisiana, Mr. Lirette is accountable to UnitedHealthcare's regional Medicaid CEO.

Angela Olden, Chief Operating Officer: Ms. Olden reports to Mr. Lirette and is responsible for the operations business unit, which includes grievance and appeals, claims administration, enrollee services, call centers, provider services, information services and encounter data. A lifelong resident of the State, Ms. Olden has oversight of Dental Benefit Providers, MARCH Vision, ModivCare and our Hudson Veteran subcontractors.

Julie Morial, M.D., Chief Medical Officer: A native of Louisiana, Dr. Morial reports to Mr. Lirette and is responsible for the clinical business unit, which includes medical management, case management and quality management. She has oversight of CareCore and OptumHealth Care Solutions.

Jose Calderon-Abbo, M.D., Behavioral Health Medical Officer: Dr. Calderon reports to Dr. Morial and has oversight of the Louisiana clinical component of United Behavioral Health, operating under the brand name Optum. Dr. Calderon shares responsibility for the management of the behavioral health services delivery system with the behavioral health coordinator.

Collin McQuiddy, Chief Financial Officer: Mr. McQuiddy reports to Mr. Lirette and is responsible for the financial business unit, which includes budgeting and forecasting, accounting system management, financial reporting and audit management.

Cedric Cloud, Pharmacy Director: A native of Louisiana, Mr. Cloud reports to Mr. Lirette and is responsible for the pharmacy business unit, with oversight of OptumRx.

Stephen Long, Contract Compliance Officer: Mr. Long reports to Mr. Lirette and our board of directors. He manages the UnitedHealthcare compliance business unit, which includes program integrity, contract compliance and fraud, waste and abuse (FWA). He oversees OptumInsight.

Health Equity Administrator: We are currently recruiting for this role that will report to Mr. Lirette and our board of directors. This leader will develop and implement our Health Equity plan established on our vision to reduce disparities in health and achieve health equity.

2.6.2.2.3 The following information about the Proposer's operating structure: this leadership reports to and …

Leading Locally with National Support

- Enable Louisiana local partnerships
- Engage a diverse workforce
- Apply local knowledge with national expertise
- Provide a comprehensive and shared secure technology platform

UnitedHealthcare of Louisiana, Inc. will continue to operate with an integrated administrative services oversight team fully dedicated to serve our enrollees and is supported by our national Medicaid services staff. The bidding entity, UnitedHealthcare of Louisiana, Inc. operates under the UnitedHealth Group, Inc. corporate structure. Louisiana has access to the expertise and resources of one of the nation's leaders in health care services, while local leadership retains autonomy and accountability. As a health plan affiliate under UnitedHealth Group, we have access to a variety of advanced, high-quality administrative services, such as information technology, claims administration and human resources. This enables us to provide support efficiently and effectively for those functions best managed through a centralized administrative office. Louisiana staff can fully focus on enrollees and providers ensuring the ability to achieve high-quality outcomes, access to care and value and affordability.

Senior Leadership: Our chief executive officer (CEO), Karl Lirette, directs our leadership team in the strategic development, growth and operations of the Medicaid Managed Care Program. This team is responsible for improving enrollee health and health equity; enabling optimal operating performance of the health plan to meet the needs of its enrollees and providers; developing appropriate provider networks and contracts to deliver access to enrollees through a high-quality network; meeting contract and regulatory requirements; implementing contract changes; and driving innovation. Mr. Lirette and the Louisiana team are supported by a broad regional and national structure to share best practices, drive innovation, and ensure resources are available to meet and exceed local Louisiana health plan needs and contract requirements. Mr. Lirette will provide key metrics and updates to our LDH performance review as required by the Model Contract.

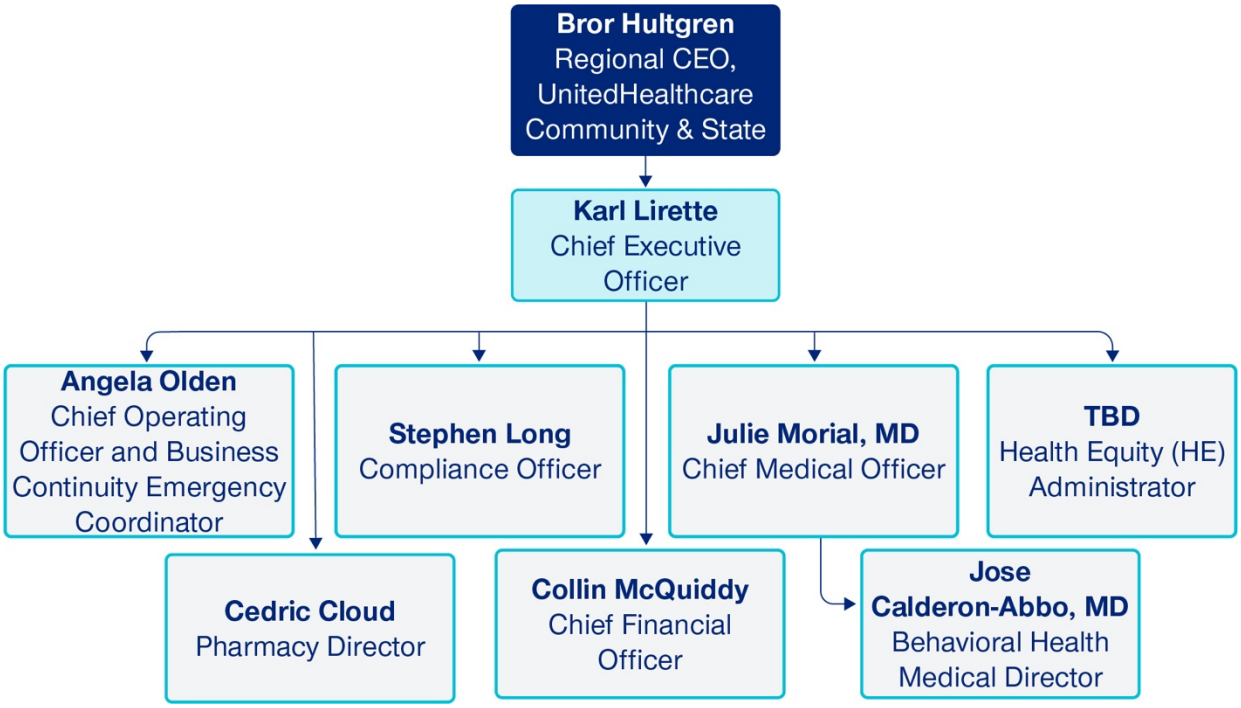


Figure 2. Senior Leadership Organizational Chart

Operations Unit: UnitedHealthcare's operations staff, led by COO Angela Olden, formulates business strategies and operational plans to enable optimal health plan performance. The unit develops appropriate provider networks; enables ready access to care; reduces complexity and administrative burden; fulfills contract and regulatory requirements; and achieves operating performance objectives. She works closely with Mr. Lirette to address strategic issues and chart the direction for the organization's future. She establishes operating metrics and daily, weekly and monthly scorecards to manage the ongoing operations to maintain contractual compliance. Ms. Olden conducts weekly operational meetings, including all Medicaid plan leaders, and reports all operational concerns to the CEO. The report includes grievance and appeals, claims administration, enrollee services, provider services, call centers, information services and encounter data. Ms. Olden receives oversight reports on Dental Benefit Providers, MARCH Vision Provider, our Veteran Hudson and ModivCare (transportation) subcontractors. Ms. Olden will provide key metrics and operational updates related to our LDH performance review as stated in the Model Contract.

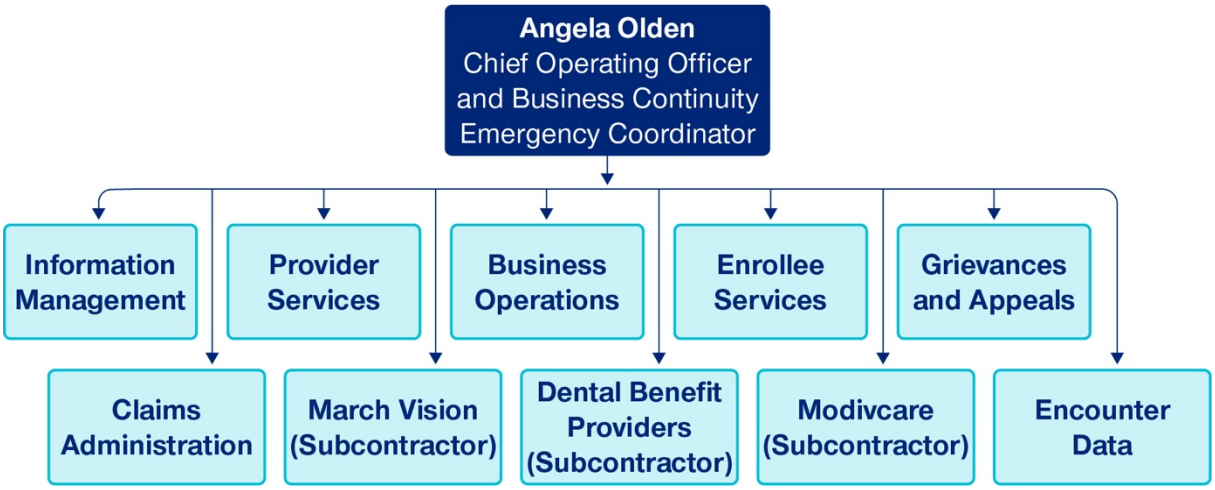


Figure 3. Operations Unit Organizational Chart

Clinical and Behavioral Health Units: Our clinical staff, led by Dr. Julie Morial, establishes and executes utilization, quality and case management strategies to meet and exceed LDH's goals and requirements. She provides medical oversight, expertise, leadership and direction for the administration of the Medicaid Managed Care Program to deliver quality health care services as defined by LDH's contract and organizational standards. She serves as a liaison with LDH's medical leadership and other stakeholders. Dr. Jose Calderon, Behavioral Health Medical Director, collaborates with Dr. Morial to validate compliance with LDH Medicaid regulations, advance behavioral-medical integration, appropriate utilization of medical resources, and monitor quality of care and quality services. Our clinical personnel monitor and act on continuous clinical quality improvement and patient safety. Dr. Morial is the head of the Quality Management Committee and is responsible for the implementation, coordination and integration of all quality management activities. She chairs the Provider Advisory and Healthcare Quality and Utilization Management Committee. Dr. Morial will provide clinical updates and key metrics related to our LDH performance review as stated in our Model Contract.

Dr. Calderon collaborates with Dr. Morial, the Behavioral Health Coordinator and the Behavioral Health staff to set the Behavioral Health strategy of the plan in alignment with LDH's priorities and vision. These include the integration of physical and behavioral health services, and behavioral health services expansion for our Medicaid Managed Care enrollees. He oversees our quality improvement initiatives regarding the appropriate use of psychotropic medications and coordinates the day-to-day operations to achieve LDH's goals. Dr. Calderon leads and directs the development of appropriate risk management strategies in collaboration with LDH, other behavioral health staff, providers and stakeholders.

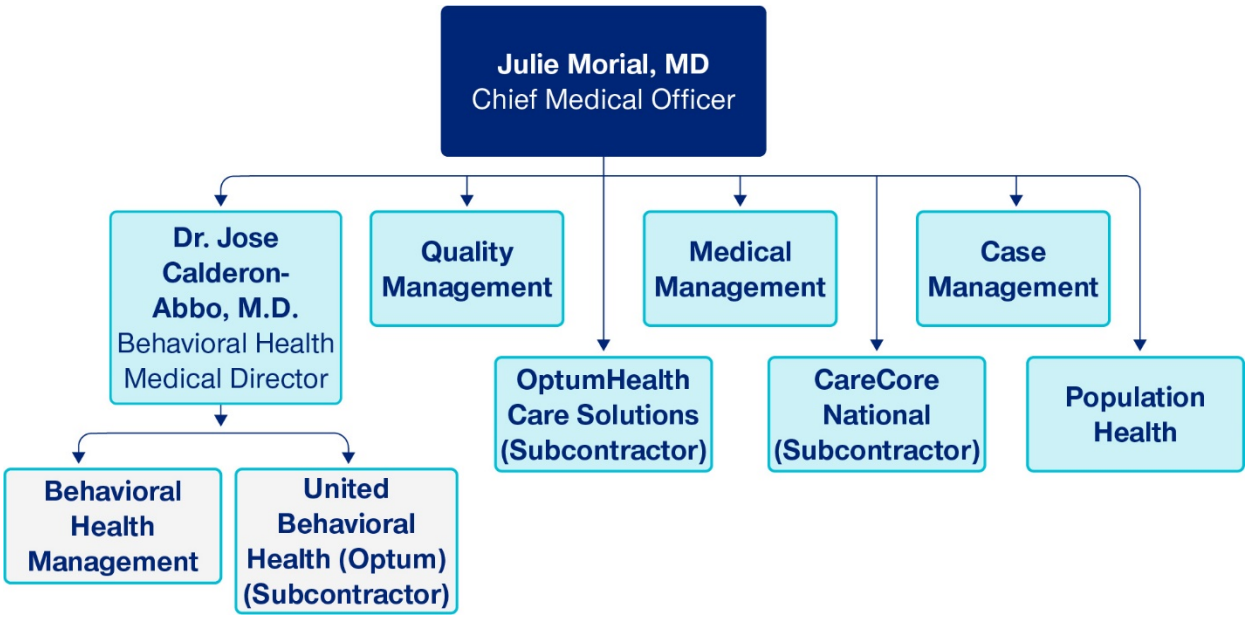


Figure 4. Integrated Clinical Unit and Behavioral Health Unit Organizational Chart – including health care staff, providers and stakeholders

Finance Unit: Chief Financial Officer Collin McQuiddy leads our finance unit. He oversees our financial operations, including standardization of items to measure and related tools and processes for encounter data, analysis and reporting. Mr. McQuiddy is responsible for collaborating with Mr. Lirette and our corporate financial team to establish a disciplined approach to financial performance management. Mr. McQuiddy oversees monthly trend analytics to evaluate unit and volume cost trends. He is responsible for evaluating monthly financials and reporting. Mr. McQuiddy will provide financial updates and key metrics related to our LDH performance review as stated in our Model Contract.

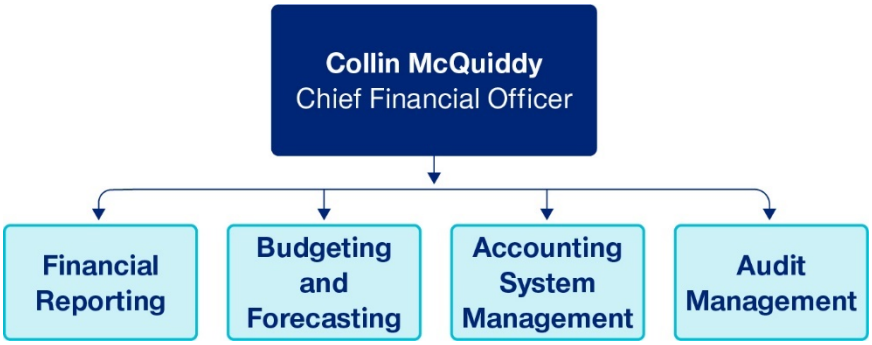


Figure 5. Finance Unit Organizational Chart

Pharmacy Unit: The pharmacy team, led by Pharmacy Director Cedric Cloud, oversees all clinical and administrative pharmacy activities, including the proper provision of pharmaceutical services to enrollees. He develops and maintains pharmacy practice standards, policies and procedures. He collaborates with Dr. Morial, Dr. Calderon and other UnitedHealthcare staff to confirm the integration of pharmacy data into UnitedHealthcare's management and quality improvement efforts in Louisiana. He provides pharmacy trend analysis and review to deliver multiple regulatory and ad hoc pharmacy reports. As the dedicated pharmacy resource for the Louisiana health plan, he is the

direct contact person for Louisiana pharmacy providers and a resource for our Louisiana health plan and national clinical and pharmacy staff. Mr. Cloud will provide key metrics and pharmacy updates related to our LDH performance review as stated in the Model Contract.

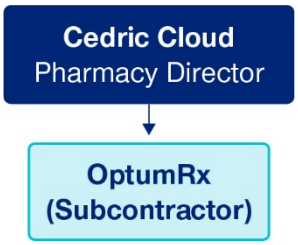


Figure 6. Pharmacy Unit Organizational Chart

Compliance Unit: Contract Compliance Officer Stephen Long collaborates with business leaders to promote the UnitedHealthcare Compliance Program, ensuring operational accountability and compliance with the contract. He serves as the point of contact for LDH and other regulatory agencies regarding compliance issues and regulatory audits. He reports to the Board of Directors and, with Mr. Lirette, co-chairs the Compliance Oversight Committee meetings. He oversees the FWA program; compliance and ethics reporting; all regulatory audits; the risk assessment process; and verifies compliance risks are proactively identified and addressed through prevention, detection, correction and monitoring strategies. He coordinates compliance training and education programs; development and implementation of appropriate corrective action; and with legal counsel, compliance investigations. He maintains compliance-related policies and procedures; verifies timely communication and education of the compliance program; works with operational leaders to validate understanding and communication regulatory contractual requirements; confirms appropriate delegated entity oversight; and verifies established processes and procedures meet regulatory and contract requirements, including a dedicated special investigations team, as stated in our Model Contract Section. There are currently 11 FTEs in the Compliance Unit.

Figure 7. Compliance Unit Organizational Chart

Our current staffing exceeds the proposed level and is based upon the current market share, which is estimated at 500,000 enrollees. We recognize Louisiana's goal to elevate the Medicaid program; therefore, we are committed to adding additional staff members who will serve as regional provider advocates. Our flexible and agile approach for appropriate staffing entails:

- **Workforce Planning:** We use a standardized Workforce Management Projection Model to accommodate membership changes and project the number of full-time equivalent (FTE)

personnel required by functional area to support membership growth and maintain or exceed contract requirements.

- **National Resources:** We deploy our national team to assist locally while we hire and train local staff. This enables our local executives and staff to focus on the daily activities of providing services and support to Medicaid Managed Care enrollees.

Senior Leadership Unit

- **FTEs:** Eight FTEs (chief executive officer, chief operating officer, chief medical officer, behavioral health medical director, chief financial officer, pharmacy director and contract compliance officer and newly developed Health Equity Administrator
- **Major Qualifications and Competencies:** Listed later as unit leads under each major functional area.
- **Team Lead:** Mr. Lirette provides overall direction, including strategic development, growth, operations and quality of UnitedHealthcare to provide innovative care to our enrollees and to reduce health disparities. He provides executive oversight and leadership to meet the needs of our enrollees and achieve contractual compliance.

Operations Unit

- **FTEs:** 335 FTEs in the operations unit (approximately 267 FTEs based upon 350,000 enrollees)
- **Major Qualifications and Competencies:** Multiple years of experience in managed care plans and with providers relevant to their respective roles — grievances and appeals (nine FTEs), claims administration –20 FTE, enrollee services (65 FTEs), information management, encounter data and provider services.
- **Team Lead:** Ms. Olden leads and serves as the primary point-of-contact for all UnitedHealthcare operational issues. She is responsible for managing and administering multiple functions and general business operations. She is responsible for formulating sound business strategies and operational plans and is accountable for operational results.

Clinical Unit

- **FTEs:** 221 FTEs in the clinical unit (approximately 171 FTEs based upon 350,000 enrollees)
- **Major Qualifications and Competencies:** RNs, LPNs, CHWs and non-clinical personnel with extensive experience in managed care. Responsible for accreditation, adherence and plan education. Our Clinical Transformation Team works with providers in our shared saving plan to address quality and utilization.
- **Team Lead:** Dr. Morial provides clinical oversight for all major clinical and quality management components of UnitedHealthcare's operations, including the integration of physical, behavioral and social health. She oversees clinical operations initiatives focused on clinical excellence and performance improvement.

Behavioral Health Unit

- **FTEs:** 104 FTEs in the behavioral health unit (approximately 82 FTEs based upon 350,000 enrollees)

- **Major Qualifications and Competencies:** Licensed behavioral health clinicians with experience serving the Medicaid population and assisting individuals with complex behavioral and emotional needs.
- **Team Lead:** Dr. Calderon leads and maintains the clinical integrity of behavioral health programs, including peer reviews, appeals and consultations with providers and other community-based clinicians, including general practitioners. He and Dr. Morial, CMO, work collaboratively with clinical, network and quality staff and interacts directly with psychiatrists, prescribers, state officials and other clinical professionals who consult on various processes and programs.

Finance Unit

- **FTEs:** Seven FTEs in the finance unit (approximately seven based upon 350,000 enrollees)
- **Major Qualifications and Competencies:** Multiple years of experience in managed care plans and the provider community relevant to budgeting and forecasting; accounting system management; financial reporting; and audit management.
- **Team Lead:** Mr. McQuiddy leads and oversees all aspects for strategic financial planning, analysis and operations for UnitedHealthcare. He oversees the budget, accounting systems, financial reporting and audit activities.

Pharmacy Unit

- **FTEs:** Six FTEs in the pharmacy unit (approximately five FTEs based upon 350,000 enrollees)
- **Major Qualifications and Competencies:** Experience in managed care pharmacy either in a health plan or PBM, including Medicaid, an understanding of state contract language, building and maintaining client relationships and networking, developing and implementing clinical programs to reduce trend or improve enrollee experience and the ability to develop tactical plans, drive performance and achieve targets.
- **Team Lead:** Mr. Cloud leads and manages the contract requirements; creates and maintains state-specific policies; and conducts pharmacy benefit analysis to support the provision of clinically appropriate, high-quality, cost-effective pharmaceutical care for our enrollees. He analyzes, reviews, forecasts, trends and presents information to leadership for operational and business planning.

Compliance Unit

- **FTEs:** 11 FTEs in the compliance unit (approx. nine FTEs based upon 350,000 enrollees)
- **Major Qualifications and Competencies:** Multiple years of experience in managed care plans and the provider community relevant to their respective roles — program integrity, compliance and FWA.
- **Team Lead:** Mr. Long oversees the UnitedHealthcare Compliance Program and serves as the primary point-of-contact for all UnitedHealthcare contract compliance issues. He provides oversight to the program integrity functions, including the special investigations unit (SIU) and payment integrity. He manages the logistics of contract deliverables and ad hoc requests for information from LDH.

Attachment 2.6.2.2.2
Karl Lirette
Chief Executive Officer

Education/Licensure/Credentials

- UnitedHealthcare Executive Development Program
- Bachelor of Science – Accounting, University of New Orleans

Professional and Community Affiliations

- Current Advisory Board member with NextHealth National Executive Advisory Council
- Current Panel member of LDH Independent Review Panel
- Current Commissioner for St. Charles Parish Housing Authority Board
- Current Board member, Ormond Civic Association, Community Board
- Completed 2017 Baton Rouge Leadership Academy with Baton Rouge Business Report
- Recipient of 2012 inaugural UnitedHealthcare President's Culture Award – Performance
- Recipient of 2006 McKesson National FinanceRx ICARE Award

Professional Experience

Current Employment:	**UnitedHealthcare of Louisiana – Metairie, Louisiana** **Chief Executive Officer**
Timeframe:	September 2019 – Present
Role and Responsibilities:	▪ Manages over $2.5 billion in annual medical expenses and oversees 600+ employees supporting UHC Community Plan, LA ▪ Oversees top Quality program with continuous top HEDIS 1st place scores among other MCOs in LA ▪ Oversees PI program that has exceeded LDH annual savings expectations ▪ Created Diversity, Inclusion, Race, Equity (DIRE) committee with plan CMO in June 2020 ▪ Oversaw investments of over $9 million back to our LA communities focused directly on addressing Disparities in Health ▪ Leader of 2019 UHC health plan RFP winning bid
Employer: Position:	**UnitedHealthcare of Louisiana – Metairie, Louisiana** **Chief Operating Officer (COO)**
Timeframe:	May 2013 – September 2019
Role and Responsibilities:	▪ Managed over $1 billion in medical expenses and oversees 400+ employees ▪ Completed UnitedHealthcare Executive Training Program 2016, Stanford University ▪ Managed marketing, network and operations teams for UnitedHealthcare

	▪ Led Louisiana implementation team for Medicaid expansion and served as guest panelist for LDH Medicaid expansion tour and Media Day with UnitedHealthcare CEOs ▪ Louisiana "Core Team" leader for writing 2015 Louisiana Medicaid RFP, first place score out of five MCOs ▪ Managed build-out of new Baton Rouge facility, staffing and training of 300+ FTEs in 2015 ▪ Created and rolled out statewide provider quality value-based contracting model ▪ Responsible for go-live implementation of 2015 full-risk RFP and 2015 behavioral health carve-in ▪ Led quarterly business reviews with LDH and Louisiana plan monthly town halls ▪ Built strong relationship with State's third-party payer, mitigating payment issues ▪ Redesigned provider service model to handle full end-to-end issues and complaints ▪ Executive sponsor for local employee engagement team ▪ Emergency plan coordinator for UnitedHealthcare with State Medicaid program
Employer: Position:	**UnitedHealthcare of Louisiana – Metairie, Louisiana** **Chief Financial Officer**
Timeframe:	December 2011 – April 2013
Role and Responsibilities:	▪ Successfully led team through first year startup, assisted with PCP network build ▪ Led build-out of newly created gain share financial model with LDH along with Mercer for "Bayou Health" program ▪ Active on go-live team resulting in first place State enrollment at 30% out of five plans ▪ Led team creating onboarding and training documents ▪ Recipient of 2012 inaugural UnitedHealthcare Community & State President's Culture Award – Performance
Employer: Position:	**The Shaw Group – Baton Rouge, Louisiana** **Controller – Air Quality Systems (AQCS)/Natural Gas – Fossil Power Division/Senior Finance Manager**
Timeframe:	April 2007 – December 2011
Role and Responsibilities:	▪ Financial lead on over $2.5 billion on six active projects, five domestic and one international ▪ Financial lead on Shaw's most financially successful project of $1.2 billion ▪ Created quarterly internal financial position papers for various complex project issues on revenue recognition or other significant financial issues

Angela Olden

Chief Operating Officer (COO)

Education/Licensure/Credentials

- Registered Nurse, Bachelor of Science, Northwestern University
- Master of Arts, Louisiana Tech, Barksdale
- Registered Nurse with State of Louisiana: RN038346

Awards

2018 New Orleans Business Woman of the Year

Professional Experience

Current Employment:	**UnitedHealthcare of Louisiana – Metairie, Louisiana** **Chief Operating Officer (COO)**
Timeframe:	May 2019 – Present
Role and Responsibilities:	▪ Manages network, population health and operations teams for UnitedHealthcare ▪ Oversee the development of the provider local support tools and ensure that all team members are educated on the activities that impact our providers ▪ Oversee the HEDIS and CAHPS process for the plan ▪ Developed and implemented BR wellness center ▪ Created and rolled out ED navigator program ▪ Continue to develop and implement VBP initiatives ▪ Built strong relationship with State's third-party payer, mitigating payment issues ▪ Executive sponsor for local employee engagement team ▪ Emergency plan coordinator for UnitedHealthcare with State Medicaid program September 2014 – May 2019 – Director of Population Health/Quality ▪ Responsible for the strategic planning, build out and implementation of the Louisiana Market Population/Quality Department ▪ Responsible for NCQA preparation and activities across all departments ▪ Responsible for developing the Committee structure for the plan ▪ Appeals and Grievances oversight ▪ Responsible for HEDIS/EPSTD activities and results
Employer: Position:	**Amerigroup – Metairie, Louisiana** **Vice President of Quality**
Timeframe:	January 2012 – September 2014
Role and Responsibilities:	▪ Responsible for the overall operations of the plan ▪ Responsible to address and ensure follow up on LDH concerns with the MCO ▪ Responsible for the strategic planning, build out and implementation of the Louisiana Market Quality and Health Plan Promotions department

	▪ Responsible for plan NCQA preparation and activities across all departments ▪ Achieved NCQA Accreditation and New Health Plan in September 2013 (18 months after FEB 2012 Go-Live date) ▪ Responsible for External State Quality audits; achieved 98% compliance score of Full/Substantial on required elements ▪ Responsible for HEDIS/EPSTD activities and results; first state Medicaid plan to conduct HEDIS hybrid data collection ▪ Responsible for plan committee structure and Board Report
Employer: Position:	**Humana, Metairie, Louisiana** **Regional Manager of Quality Management for the Louisiana/Mississippi Market**
Timeframe:	April 2004 – January 2012
Role and Responsibilities:	▪ Responsible for all quality activities for this market ▪ Responsible for the accreditation activities (NCQA and CMS) for market and ensured compliance with all standards; coordinated with all health plan departments their compliance activities • Addressed quality of care member issues and coordination with the risk management department to ensure risks to the company were addressed in an appropriate manner. • 2007 NCQA Accreditation for Commercial and Medicare- Excellent and CMS Deeming status achieved. • 2010 NCQA Accreditation for Commercial and Medicare-Excellent. • 2011 NCQA Medicare-Excellent rating and Special Needs plans accredited.

Julie Morial, M.D., MPH, FACP

Chief Medical Officer

Education/Licensure/Credentials

- Doctor of Medicine, University of Pennsylvania, Perelman School of Medicine
- Master of Public Health, Concentration in policy and administration, University of California Berkeley
- Bachelor of Arts – Anthropology with a concentration in Biological Sciences, Yale University

Professional and Community Affiliations

- Board Member, Louisiana Policy Institute for Children, 2016 – Present
- Board Member, National Diversity Advisory, Louisiana State University, 2011 – Present
- Chair Healthcare Outreach Committee, Smoking Cessation Trust for Louisiana, 2011 – Present
- Member, American College of Physicians 1990 – Present
- Member, Board of Directors, Cancer Services of Greater Baton Rouge, Executive Committee, 2010 – 2016
- Member, American Society of General Internal Medicine 2003-2006
- Professional Awards:
  - Healthcare Hero Award, New Orleans City Business, May 2018
  - *The American Health Strategy and Quality Institute*, The Right Track Quality in Care Award, October 2015
  - Ursuline Academy Ursuline Update, *Alumnae Spotlight*, August 2008
- Disease Management Awards:
  - *Annual Forum of Healthcare Effectiveness* 2005 Statewide Public Hospital and Ambulatory Centers Initiatives, Medical Center of Louisiana, New Orleans
    - First Place-*Cancer Strategy*: Cancer Screening Clinical Improvement
    - Third Place-*Cancer Strategy*: Cancer Screening Clinical Excellence
    - Second Place-*Congestive Heart Failure Strategy Group*: CHF Clinical Improvement
    - Third Place-*HIV Strategy Group*: Clinical Improvement

Professional Experience

Current Employment:	**UnitedHealthcare of Louisiana – Metairie, Louisiana** **Chief Medical Officer**
Timeframe:	November 2017 – Present
Role and Responsibilities:	▪ Drives strategy and clinical value focused on quality, affordability and service while ensuring the voice of Louisiana's enrollees and providers; focuses on the effective use of data to drive transformation ▪ Works in concert with UnitedHealthcare and United Clinical Services (UCS) clinical operations and national affordability teams to ensure total medical PMPM performance targets and value-based risk sharing purchasing; activities include Joint Operations Committee (JOC), data sharing, health care affordability initiatives and ensuring appropriate levels of inpatient or outpatient and ED utilization

	▪ Delivers clinical excellence; assists with HEDIS® data collection process, CAHPS® improvement while driving UnitedHealthcare accreditation activities and quality rating initiatives for the local CMS plan; assists in the implementation of value-based and risk-sharing purchasing models with the integration of these models across quality, evidence-based guidelines of care, utilization and strategic goals ▪ Uses and maintains strong working knowledge of all government mandates and provisions for the local UnitedHealthcare health plan to ensure compliance and engagement of all stakeholders across the health care spectrum ▪ Leads transformation of health system through clinical interface and communication with care providers and UnitedHealthcare network management ▪ Creates strategies and relationships that drive Triple Aim for patient-centered medical home access, quality and affordability ▪ Identifies new opportunities by participating in regional and local Medical Cost Operating Teams (MCOTs), national MCOT and JOCs ▪ Oversees performance of United Behavioral Health including behavioral health and medical care integration and OptumHealth
Employer: **Position:**	**Peoples Health – Baton Rouge, Louisiana** **Corporate Market Medical Director**
Timeframe:	May 2010 – October 2017
Role and Responsibilities:	▪ Served as market medical director for the Capital Region of Peoples Health, a Medicare Advantage MCO that provides patient-centered medical care to seniors and the dually eligible population; charged with building the infrastructure and relationships that inform and educate physicians across the Baton Rouge community about quality initiatives — and virtual navigation — related to chronic disease management, long-term acute care, care coordination, risk adjustment and adherence ▪ Built system that ensured correct physician documentation, preventive measures and patient assessment ▪ Implemented initiatives that took Star scores from poor performance (2.5) to excellent (4.0), while markedly improving Risk Scores to No. 1 performer (compared to seven other established markets) in the Peoples Health ▪ Significantly improved overall financial performance through progressive cost containment efforts with physicians, physician practices and partner health care institutions ▪ Established a face-to-face presence with membership, and on a business level that did not exist previously; significantly improved collaboration and alignment and created impetus to deliver timely and appropriate care ▪ Served as market medical director for the Capital Region of Peoples Health, a Medicare Advantage MCO that provides patient-centered medical care to seniors and the dually eligible population; charged with building the infrastructure and relationships that inform and educate physicians across the Baton Rouge community about quality initiatives — and virtual navigation — related to chronic disease management, long-term acute care, care coordination, risk adjustment and adherence

	▪ Built system that ensured correct physician documentation, preventive measures and patient assessment ▪ Implemented initiatives that took Star scores from poor performance (2.5) to excellent (4.0), while markedly improving Risk Scores to No. 1 performer (compared to seven other established markets) in the Peoples Health ▪ Significantly improved overall financial performance through progressive cost containment efforts with physicians, physician practices and partner health care institutions ▪ Established a face-to-face presence with membership, and on a business level that did not exist previously; significantly improved collaboration and alignment and created impetus to deliver timely and appropriate care
Employer: Position:	**Blue Cross Blue Shield (BCBS) of Louisiana – Baton Rouge, Louisiana** **Associate Medical Director/Medical Director**
Timeframe:	June 2006 – April 2010
Role and Responsibilities:	▪ Grew disease management (DM) program from a group limited to diabetes and heart failure for a small segment of the population (2006) to highly successful, highly populated, whole person DM model focusing on a suite of conditions — COPD, asthma, coronary heart disease and diabetes ▪ Drove improved communication and collaboration across team, significantly improving return on investment for this fledgling organization created in parallel to company vision ▪ Recognized by the Federal Employee Program Director's office (2011) as a “best practice among the other 39 BCBS state plans” ▪ Collaborated with DM manager and analytics team to develop program evaluation measures that monitored clinical outcomes and program success ▪ Designed and launched enrollee assessments that allowed health coaches to capture demographic data to address health disparities and health literacy ▪ Facilitated hiring of nationally recognized physician, Dr. Villagra, to perform third-party clinical review of diabetes program, adding significant credibility to the program, especially for the physician community ▪ Led review and assessment of nine local and national DM vendors, leading to decision to offer an internal program rather than outsourcing — a highly efficient and effective decision

Jose Calderon-Abbo, M.D. FASAM

Medical Director for Behavioral Health

Education/Licensure/Credentials

- Medical Doctor- National Autonomous University of Mexico, Mexico City, Mexico
- Psychiatry – Wayne State University/Sinai Hospital, Detroit, MI
- Addiction Medicine- American Board of Addiction Medicine
- Internal Medicine Transitional Internship, Wayne State University/Sinai Hospital, Detroit, MI
- Active unrestricted medical license LA # MD.14816R
- Inactive unrestricted medical license MI

Professional and Community Affiliations

- Associate Professor of Clinical Psychiatry, LSUHSC, Department of Psychiatry. New Orleans, LA
- Sr. Faculty, Center for Mind-Body Medicine, Washington, D.C.
- Fellow, American Society of Addiction Medicine. Chevy Chase, MD
- Advisory Board, Anti-Defamation League South Central Chapter (LA, MS, AK)
- Advisory Board, Shatterproof LA
- Advisory Council on Heroin and Opioid Prevention and Education, Louisiana
- Chair, Louisiana Managed Medicaid Association, Behavioral Health Subcommittee

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Metairie, Louisiana** **Medical Director for Behavioral Health**
Timeframe:	March 2018 – Present
Role and Responsibilities:	▪ Provides oversight to and direction of the behavioral health, medical-behavioral integration, equity and diversity programs at UnitedHealthcare ▪ Interacts directly with psychiatrists, behavioral health providers and other clinical professionals who consult on various processes and programs ▪ Expands and manages development and implementation of evidence-based treatments and medical expense initiatives and will advise leadership on health care system improvement opportunities ▪ Maintains the clinical integrity of the program, including timely peer reviews, credentialing, quality, appeals and consultations with providers and other community-based clinicians, including general practitioners ▪ Works collaboratively with the medical director, clinical, network and quality staff

Employer: Position:	**Imagine Recovery, New Orleans, Louisiana** **Medical Director, Intensive Outpatient Program**
Timeframe:	June 2018 – August 2019 – Psychiatrist August 2019 – Present – Medical Director, Intensive Outpatient Program
Role and Responsibilities:	▪ Oversee clinical-medical care of patients, and offer support to clinical teams ▪ Direct patient care and supervision of staff psychiatrist ▪ Education and support to family members ▪ Educational activities for the community at large and for healthcare providers throughout the State
Employer: Position:	**University Medical Center of Louisiana LCMC – New Orleans, Louisiana** **Associate Medical Director Co-Occurring Disorders Program**
Timeframe:	August 2015 – February 2018 and March 2009 – July 2015
Role and Responsibilities:	▪ Oversaw program development, clinical and quality integrity of the co-occurring disorders unit at University Medical Center ▪ Served as liaison to the Louisiana State University School of Medicine teaching and supervising medical students, residents in training and other health-allied professionals ▪ Participated in hospitals quality improvement, compliance and other administrative functions
Employer: Position:	**Center for Mind-Body Medicine, Washington DC** **Sr. Faculty Mind-Body Medicine**
Timeframe:	June 2008 – Present
Role and Responsibilities:	▪ Development and delivery of professional certification trainings on mind-body medicine skills ▪ Professional and public educational sessions on mind-body medicine skills ▪ Participated in hospitals quality improvement, compliance and other administrative functions

Collin McQuiddy

Chief Financial Officer

Education/Licensure/Credentials

Bachelor of Science, Accounting, Miami University, Oxford, Ohio

Professional and Community Affiliations

Certified Public Accountant

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Metairie, Louisiana** **Chief Financial Officer**
Timeframe:	June 2020 – Present
Role and Responsibilities:	▪ Oversee the health plan's $2.5 billion, annual financial goals and objectives ▪ Provide monthly financial reporting of key initiatives ▪ Provide ongoing financial analysis of development and operational results against the budget ▪ Provide analysis and support for developing ideas, programs, and projects ▪ Serve as a member of the diversity and inclusion committee
Employer: Position:	**LHC Group, Inc., Lafayette, Louisiana** **Chief Accounting Officer**
Timeframe:	May 2019 – June 2020
Role and Responsibilities:	▪ Provides leadership and oversight of all aspects of the accounting function of the organization, inclusive of oversight of all external financial reporting functions, treasury transactions, tax related matters, coordination of the external audit and partnering with finance and operations to assist in understanding how the company's overall corporate strategy is performing against its financial performance ▪ As Part of the senior leadership team works with all departments to understand processes and how technology can be leveraged to improve scalability and accuracy ▪ Monitors dashboard reports that provided financial scorecard of current month results to expectations ▪ Integrated finance education and oversight into medical management and operational decision-making process ▪ Provides oversight on departmental budgeting and forecasting
Employer: Position:	**Louisiana Healthcare Connections (subsidiary of Centene Corporation), Baton Rouge, Louisiana** **Vice President Finance**
Timeframe:	November 2015 – February 2019
Role and Responsibilities:	▪ Provided leadership and oversight of all aspects of finance for the health plan, inclusive of developing and monitoring progress toward annual

	operating plan, monitoring medical cost trends and working with medical management and operations to develop cost improvement initiatives and working directly with the State and their actuaries in rate setting and risk score activities ▪ Developed dashboard reports that provide financial scorecard of current month results to expectations ▪ Integrated finance education and oversight into medical management and operational decision-making process ▪ Streamlined budgeting and forecasting process ▪ Developed network strategic plan to improve membership mx by region
Employer: Position:	**CB&I – Federal Services, Baton Rouge, Louisiana** **Financial Planning Analyst**
Timeframe:	January 2015 – November 2015
Role and Responsibilities:	▪ Provided oversight and supervision of all planning and analysis for Federal Services division to support the business segment's operating strategy ▪ Developed a weekly forecast of revenue and gross profit by project ▪ Streamlined monthly financial reporting process through utilization of various financial reporting tools ▪ Developed a rolling 12 month forecast by line of business ▪ Standardized backlog reporting process utilized within our three lines of business
Employer: Position:	**Edgen Group, Inc., Baton Rouge, Louisiana** **Director of Financial Reporting/Corporate Controller**
Timeframe:	January 2013 – October 2014
Role and Responsibilities:	▪ Provided oversight and supervision of all internal and external financial reporting, worldwide consolidation of group with over 35 domestic and international locations in 18 countries, direct oversight and continued improvement of all budgeting and forecasting processes, quarterly reporting of results to the Board of Directors and Audit Committee, coordination of external audit relationship, and technical accounting research ▪ Implemented system of additional financial controls to mitigate risk associated with shorter close cycle
Employer: Position:	**Metric Stream, Inc., Baton Rouge, Louisiana** **Senior Director GRC Solutions**
Timeframe:	May 2012 – December 2012
Role and Responsibilities:	▪ Managed client relationships from end of sales cycle to delivery of final product working with international team of developers and project managers and pursuing additional growth opportunities within my client base as well as within the industries that they served

Employer: Position:	**Angelle Concrete Group, LLC, Baton Rouge, Louisiana** **Director of Accounting and Finance**
Timeframe:	October 2011 – May 2012
Role and Responsibilities:	▪ Provided oversight of all accounting, financial reporting, accounts payable and payroll functions within the organization; monthly reporting to both senior debt holders and Board of Directors; and daily cash management activities for 15 locations with one line of credit
Employer: Position:	**Amedisys, Baton Rouge, Louisiana** **VP of Enterprise Risk Management**
Timeframe:	May 2006 – October 2011
Role and Responsibilities:	▪ Developed and implemented an ERM process to streamline the various risk and compliance functions within the organization and managed a new steering committee ▪ Designed and managed the implementation of a web-based software solution that allowed over 500 home health and hospice agencies to effectively communicate revenue adjustments to the corporate office in Baton Rouge

Cedric Cloud, PharmD.

Pharmacy Director

Education/Licensure/Credentials

- Doctor of Pharmacy, Xavier University of Louisiana
- State Licensure: Virginia Board of Pharmacy, #0201106338; Texas Board of Pharmacy, #4338; Louisiana Board of Pharmacy, #17337 (Renewal in progress)

Professional Experience

Current Employment:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana** **Pharmacy Director**
Timeframe:	November 2020 – Present
Role and Responsibilities:	▪ Manage the Pharmacy benefits for the Louisiana United HealthCare Plan to ensure compliance with State contract expectations and state mandated preferred drug list requirements; submission of state-driven formulary change requests to the pharmacy benefit manager (PBM), and validation of implementation as intended ▪ Collaborate with health plan leadership to support the operational, clinical and regulatory compliance goals of the health plan and that of United HealthCare overall ▪ Provide vigilance regarding pharmacy trends using an array of internal and external reporting tools with the intent of discovering opportunities for improving the efficiency of drug spend, and for implementation of utilization management tools; ensure appropriate medication access for plan membership ▪ Attend and participate State pharmacy meeting calls; exact PBM oversight via monitoring of Louisiana-specific monthly service level standards, weekly claims auditing, and by monitoring compliance with the Louisiana Preferred Drug and brand-over-generic lists
Employer: Position:	**Aetna Health (Medicaid) – Phoenix, Arizona** **Pharmacy Service Manager**
Timeframe:	June 2019 – November 2020
Role and Responsibilities:	▪ Coordinated and supported formulary activities by submission of formulary change requests, analysis of clinical and financial information (Medispan file, PBM new drug monographs, weekly AWP File reviews, quarterly Drug Class Review) in addition to the use of established formulary management tools and principles to maximum financial efficiency with appropriate medication access for plan membership

Employer: Position:	**Aetna Health (Medicaid) – Phoenix, Arizona** **Assistant Clinical Pharmacy Manager – Intern (Pharmacy Service Manager)**
Timeframe:	January 2018 – June 2019
Role and Responsibilities:	▪ Worked with the Prior Authorization department; supported the lead clinical pharmacy manager with pharmacy trend reporting, adherence data tracking; collaborated with Pharmacy & Therapeutics (P&T) Committee members, Nurse Case Management teams, and other members of the State plan leadership to ensure all company goals and intended outcomes would be realized
Employer: Position:	**Aetna Health (Medicaid) – Phoenix, Arizona** **Pharmacy Program Manager/Clinical Pharmacist**
Timeframe:	June 2013 – January 2018
Role and Responsibilities:	▪ Responsibilities included prior authorization and formulary exception review for State Medicaid plans, quarterly review of prior authorization guidelines and criteria updates ▪ Collaborated with pharmacy plan directors and pharmacy operations leadership to ensure formulary management adherence
Employer: Position:	**ACS/Xerox, Houston, Texas** **Clinical Pharmacist**
Timeframe:	February 2013 – June 2013
Role and Responsibilities:	▪ Performed clinical drug utilization review for Medicare Part D (Silverscript) members ▪ Assisted management with basic aspects of Formulary Management
Employer: Position:	**College Park Pharmacy, The Woodlands, Texas** **Pharmacist in Charge**
Timeframe:	June 2012 – January 2013
Role and Responsibilities:	Directed daily pharmacy operations

Stephen J. Long, Certified in Healthcare Compliance

Compliance Officer

Education/Licensure/Credentials

- Bachelor of Science-Political Science, Salem State College, Salem, MA
- Certified in Health Care Compliance

Professional Experience

Current Employment:	**UnitedHealthcare Community Plan – Metairie, Louisiana** **Compliance Officer**
Timeframe:	May 2021 – Present
Role and Responsibilities:	▪ Implement and oversee the UnitedHealthcare Compliance Program ▪ Monitor fraud, waste and abuse compliance ▪ Monitor compliance to LDH contract requirements and federal and State regulations ▪ Act as principal point of contact between LDH business owners and UnitedHealthcare resources
Employer: Position:	**Peoples Health – Metairie, Louisiana** **Multiple Positions**
Timeframe:	▪ 2020 – 2021: Director of Regulatory Adherence ▪ 2003 – 2020: Medicare Compliance Officer ▪ 2003 – 2011: Director of Appeals and Grievances ▪ 2000 – 2004: Claims Manager ▪ 1997 – 2000: Enrollment Analyst
Role and Responsibilities:	▪ Coordinated health plan activities with enterprise compliance, regulatory, audit and program integrity functions ▪ Developed, implemented, and maintained the Medicare Compliance Program inclusive of Fraud, Waste and Abuse program ▪ Responsible for managing the commercial and Medicare member appeals and grievances department ▪ Responsible for managing the commercial and Medicare claims processing department ▪ Responsible for processing and reconciling commercial enrollment

2.6.3 Enrollee Value-Added Benefits [15-page limit]

2.6.3.1 The Proposer should identify whether it proposes to offer any of the following optional value-added …

Value-added benefits require a true coordination of services by UnitedHealthcare to promote better health outcomes for enrollees and educational, preventive and outreach services. We design our value-added benefits to encourage enrollee engagement in targeted activities to build healthy behaviors and improve health outcomes. We are providing value-added benefits that are culturally sensitive, evidence-based, tie into HEDIS measures, and support integration of physical and behavioral health services (both mental health and substance abuse).

The design and implementation of value-added benefits is in accordance with the Model Contract. Among other benefits described in Section 2.6.3.2, UnitedHealthcare will provide all of the value-added benefits listed in the RFP:

- Evidence-based non-pharmacologic alternatives to opioids for chronic pain management services for adults
- Respite care model targeting homeless persons with post-acute medical needs
- Newborn circumcision benefits
- Tobacco cessation benefits, other than medications and in-office tobacco cessation counseling services
- Vision benefits for adults, including annual exam and glasses or contacts
- Identification and remediation of health-harming environmental factors related to an enrollee's shelter
- Nonclinical home-based interventions for asthma
- Comprehensive, evidence-based, longitudinal home visiting programs for pregnant and postpartum enrollees and their newborns

The following tables provide the detailed information on each of our value-added benefits. This addresses 2.6.3.3 (2.6.3.3.1 through 2.6.3.3.5), 2.6.3.4 and 2.6.3.5. We include the PMPM actuarial value in each table and the required statement from our actuary as Attachment 2.6.3.4 Signed Actuarial Statement.

2.6.3.1.1 Evidence-based non-pharmacologic alternatives to opioids for chronic pain management services for …

In Louisiana, nearly 40% of the 1,140 reported drug overdose deaths in 2018 involved opioids — a total of 444 fatalities. The Centers for Disease Control report that Louisiana overdose deaths rose almost 52% to 2,016 deaths in 2020 among the largest increase in the country. This takes a particularly heavy toll in Region 1, where we have the highest number of enrollees with diagnosed substance use disorder. As we partner with LDH to simultaneously address the challenges of reducing opioid related overdose deaths and addressing the burden of untreated pain, we provide access to non-opioid therapies and alternatives to help decrease the adverse consequences of inappropriate opioid prescribing.

Our multi-faceted pain management value-added benefit for Louisiana enrollees is designed to empower enrollees to access alternative treatments that address chronic pain conditions/ailments to improve health outcomes. This benefit helps enrollees avoid unnecessary and costly emergency care and pain-related hospitalizations by receiving access to alternative treatments like chiropractic care, acupuncture, mindfulness exercises, and an exercise therapy program inclusive of digital

interaction and gym membership. **We have seen a 42% increase in chiropractic utilization from 2018 to 2020, while driving down inpatient admissions by 22% for 1,500 enrollees with opioid use disorder (OUD) who are engaged in case management.**

Evidence-based non-pharmacologic alternatives to opioids for chronic pain management services for adults	
Populations who may receive the benefit	Enrollees over 21 are eligible to receive this benefit. Gym memberships/exercise therapy will be provided to enrollees referred through case management based upon adult BMI of 30 or greater.
Scope of benefit: **Descriptions, where applicable** **Comparison** to Louisiana Medicaid **Procedure codes**	▪ **Description**: We provide 24 visits per calendar year to an in-network chiropractor or acupuncturist. This additional health benefit does not require a prior authorization**. UnitedHealthcare has 100% access for urban and metro Louisiana for our chiropractic and acupuncture network.** ▪ 24 hours a day, seven days a week, access for enrollees to engage in mindfulness exercises from their home through our Enrollee Portal. ▪ Access to Sanvello, a self-help digital application that uses clinically validated techniques (e.g., cognitive behavioral therapy and mindfulness) to help reduce the effects of toxic stress, depression, and anxiety. Sanvello focuses on empowering individuals to improve their mental health via healthy interaction with tools and activities on their smartphone. ▪ Gym membership (annual or monthly gym and exercise therapy) for members who qualify through case management based upon their BMI ▪ Additionally, we will provide exercise therapy via Digital Fitness courses for all enrollees. ▪ **Comparison to Louisiana Medicaid coverage**: Louisiana Medicaid does not provide coverage for chiropractic services or gym and exercise therapy for adults. ▪ **Procedure codes:** 98940, 98941, 98942, 98943, 97810, 97811, 97813, 97814, 97010, 97112, 97140
Proposed copayments	$0
How the benefit will be provided to enrollees	Enrollees access the chiropractic/acupuncture benefit by visiting an approved provider within our contracted network. We offer transportation support to access these services if needed. If an enrollee is identified for case management, our case management team can refer and connect enrollees to these providers or services. We provide mindfulness exercises and access to our Digital Fitness course and the Sanvello app through the Enrollee Portal; education on this benefit is in our welcome packet, including the *Enrollee Handbook*. Gym memberships will be coordinated upon referral from case managers with the enrollee's location and preferences in mind.
Oversight of the value-added benefit	Dr. Morial and Director of Clinical Services Nicole Thibodeaux oversee this benefit through monthly reviews of enrollee-level utilization reports and crosswalks to case management referral reporting. We use this information to identify additional education needs of our case management staff as to the availability of the benefit. We screen enrollees who use the benefit for case management if a referral or

Evidence-based non-pharmacologic alternatives to opioids for chronic pain management services for adults	
	current case management is not already in place. In addition, enrollees can self-refer to receive chiropractic or acupuncture visits.
PMPM actuarial value assuming enrollment of 350,000 enrollees	$0.25 ($0.09 for chiropractic/acupuncture; $0.10 for digital apps; $0.06 for gym membership)
Available for the 36-month term plus extensions	Yes
How this benefits our enrollees	▪ Improves the underlying challenges of chronic pain treatment and steers beneficiaries away from potentially addictive opioids for long-term pain, reducing pain and promoting holistic health

2.6.3.1.2 Respite care model targeting homeless persons with post-acute medical needs. Model shall address …

According to HUD, homelessness in Louisiana increased by 7.9% in 2019, and the pandemic has exacerbated the issue both in New Orleans and nationally. In 2019 UnitedHealthcare hired a housing liaison and created the Housing Solutions Program, which includes respite. Based upon membership data and need, the Housing Solutions Program launched a collaboration with community partners to address respite and housing needs in the Greater New Orleans area with plans of expanding partnerships and respite services to regions with the greatest need, including Baton Rouge (Region 2) in 2021 and Shreveport (Region 7) and Lafayette (Region 4) in 2022. Based upon August 2021 hotspot data for Louisiana homeless enrollees by region, this table supports our response to communities with the highest need — strategically engaging and meeting the needs for respite care.

Louisiana Region	Unique Homeless Enrollee Count	Homeless Percentage by Region
1	688	29.41%
2	410	17.53%
3	168	7.18%
4	322	13.77%
5	124	5.30%
6	93	3.98%
7	218	9.32%
8	130	5.56%
9	186	7.95%
TOTAL	2,339	

UnitedHealthcare's national Housing + Health approach has shown a 32% increase in PCP visits for enrollees, signaling that homeless enrollees are enabled by a more stable living situation to receive regular medical attention. In August 2021, we launched a **$220,000 initiative to expand our Housing + Health model** in partnership with the Ozanam Inn. This program will provide enrollees room and board, intensive case management and life skills training for three to four months (or longer, if needed) while Ozanam works to secure permanent housing.

Our medical respite approach aligns with National Health Care for the Homeless Council (NHCHC) Medical Respite Standards and guides our engagement with partners and providers who share this same vision to create the **first medical respite program meeting NHCHC standards in Louisiana**. While integrating behavioral health and counseling services, UnitedHealthcare's medical respite programs provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. With over 35 years of local experience combining the benefits of a traditional shelter along with access to medical benefits, Ozanam Inn, our trusted community partner, was an obvious choice for our respite program for the New Orleans region. In addition to the $220,000 Housing + Health investment, we

have committed a **$100,000 investment and capacity-building support** for Ozanam to create the first accredited medical respite program in Louisiana. This funding will allow Ozanam to enhance our existing medical transition assistance partnership by incorporating expanded onsite medical services through their partnership with Healthcare for the Homeless, Tulane, and LSU.

Our Valuable Partner for Respite Care
"Ozanam Inn is extremely grateful for our partnership with UnitedHealthcare and the time, effort, and considerable energy they have put into each aspect of the collaborations between our two organizations to aid and assist the homeless population in our community."

— *Renée B. Blanche, Ozanam Inn, Deputy Director/Director of Development*

In addition to our New Orleans-based partnership, UnitedHealthcare is committed to meeting the needs of our homeless membership in Baton Rouge and Shreveport by providing a value-added benefit that is accessible, inclusive, and evidence based.

Medical Respite Services for Homeless Persons	
Populations who may receive the benefit	Enrollees in the Baton Rouge and Shreveport areas who are homeless, as defined in 42 U.S.C. §254b
Scope of benefit **Descriptions, where applicable** **Comparison to Louisiana Medicaid** **Procedure codes**	▪ **Description:** We have secured respite beds for our enrollees through multiple trusted community partners such as Open Health in Baton Rouge. Respite services are in addition to post-acute clinical care and care coordination; wraparound support services, including housing (and supportive housing), identification of community resources, peer and social support, assistance with applications for SSI/SSDI, food stamps and other federal and State benefit programs. ▪ Accessible accommodations: A bed (24 hours a day), on-site showering and laundry (facility or service), secure storage for belongings and medications and three meals a day ▪ Staff (clinical and non-clinical): Wound care, durable medical equipment (DME), and care coordination services in addition to 24-hour onsite staff and access to 24-hour on-call medical support (NurseLine for non-emergency medical inquiries) ▪ Length of stay: Limited to the period necessary for complete medical recovery. Once the enrollee is medically stable, we will connect them to the health and community supports they need to stabilize and thrive in the community, including assistance with obtaining safe, affordable housing. As our experience with our partners increases, we will consider opportunities for medical respite before surgery as appropriate. ▪ Transportation to access this benefit at available community facilities, organized by housing solutions team ▪ **Comparison to Louisiana Medicaid:** Currently, there are no formal medical respite programs in Louisiana; therefore, Louisiana Medicaid does not provide coverage. Instead, homeless enrollees with post-acute recovery needs may receive a higher level of care than necessary or be at greater risk for readmission or ED visits due to the inability to recuperate in an appropriate environment. ▪ **Procedure Codes:** N/A; paid by invoice
Proposed copayments	$0

Medical Respite Services for Homeless Persons	
How the benefit will be provided to enrollees	We identify the most appropriate hospital facilities based upon admission and ED rates for enrollees who are homeless. Enrollees access medical respite through discharge planning staff. We have developed clear protocols for identifying individuals who can be safely discharged to medical respite immediately upon release.
Oversight of the value-added benefit	Medicaid Growth Lead Felice Hill, in coordination with Dr. Julie Morial, will oversee the service. Dr. Morial and her clinical team will review utilization reports and reports on the economic impact of medical respite on UM collectively with medical respite partners and relevant providers each quarter, at a minimum. Catina Griffin, RN, our housing liaison and her housing solutions program team will consist of a community health worker, a social worker, our health equity administrator and an SDOH lead. This team will be under our health equity department.
PMPM actuarial value assuming enrollment of 350,000 enrollees	$0.02
Available for the 36-month term plus extensions	Yes
How this benefits our enrollees	▪ Access to a safe shelter to properly rest and recuperate ▪ Reduces unnecessary ED visits, readmissions, and hospitalizations; leads to cost savings and enhanced quality of life. ▪ Promotes coordinated integrated care (e.g., social, medical, behavioral) and improved health outcomes

2.6.3.1.3 Newborn circumcision benefits;

With coverage of over 11,000 births annually in our enrollee population, we celebrate and support each newborn in Louisiana. According to the American Academy of Pediatrics, the "health benefits of newborn male circumcision outweigh the risks" as circumcision helps prevent urinary tract infections, penile cancer and transmission of sexually transmitted infections, including HIV. Providing this benefit builds enrollee trust in a health system that is sensitive to their personal and cultural priorities. We covered 3,439 circumcisions among our 5,548 male infants delivered in 2020.

Newborn Male Circumcision	
Populations who may receive the benefit	Newborn male enrollees
Scope of benefit **Descriptions, where applicable** **Comparison to Louisiana Medicaid** **Procedure codes**	▪ **Description:** We will provide circumcisions for newborn males in the hospital or a physician's office. ▪ **Comparison to Louisiana Medicaid coverage:** Louisiana Medicaid does not provide coverage for circumcisions. We educate providers on this benefit through the *Care Provider Manual* so they can discuss with the mother, alongside covered pregnancy related and EPSDT services. ▪ **Procedure codes:** 54150, 54160, 54161
Proposed copayments	$0
How the benefit will be provided to enrollees	Newborn male infants can receive circumcisions without a prior authorization if performed before discharge from a newborn nursery or in the physician's office within 30 days after birth. Our prior authorization

Newborn Male Circumcision	
	staff will review all requests after 30 days of birth for medical necessity. We provide education on this benefit in our welcome packet, the *Enrollee Handbook* and perinatal education.
Oversight of the value-added benefit	Dr. Morial and Ms. Thibodeaux, and our clinical team conducts oversight of this benefit through monthly claims and utilization reports at the enrollee level.
PMPM actuarial value assuming enrollment of 350,000 enrollees	$ 0.14
Available for the 36-month term plus extensions	Yes
How this benefits our enrollees	▪ Less risk of urinary tract infections ▪ A reduced risk of some sexually transmitted diseases; protection against penile cancer and a lower risk of cervical cancer in female sex partners ▪ Prevention of balanitis (inflammation of the glans) and balanoposthitis (inflammation of the glans and foreskin) ▪ Prevention of phimosis (the inability to retract the foreskin) and paraphimosis (the inability to return the foreskin to its original location)

2.6.3.1.4 Tobacco cessation benefits, other than medications and tobacco cessation counseling services;

Smoking continues to be the leading cause of premature and preventable deaths and disabilities in the United States. According to CDC statistics over 7,000 adults in Louisiana die from smoking-related illnesses annually. UnitedHealthcare is pleased to offer Quit For Life®, in addition to the State's current benefits, as a part of our value-add services. Quit For Life is an evidence-based tobacco cessation program grounded in more than 35 years of physical, psychological and behavioral health science and clinically proven approach to overcoming nicotine dependence. This program has been enhanced with the changing trends in tobacco use to include more text- and digitally enabled outreach, and content specifically designed for vaping.

As part of our evolution to meet the changing needs of Louisianians wanting to quit tobacco, UnitedHealthcare via Quit For Life will offer to our tobacco users five program sessions with a Quit Coach, though the enrollee's choice of how to connect. We are offering the option of our traditional telephonic approach, one-on-one texting or chatting with a Coach, expert-led online courses, and group video to bolster peer support.

We recognize the high impact of smoking during pregnancy and the need for tailored and specialized care within this population. We are pleased to offer seven to 10 sessions tailored to women who are trying to become pregnant, are currently pregnant, are post-partum or are breastfeeding. Some of the key elements of this program include an extended care program, in which quit coaches conduct three additional calls to help mothers who have quit prepare for a smoke-free postpartum stage; one 30 days before the due date and two calls within 45 days of the baby's delivery. We send these a quit guide, Need *Help Putting Out That Cigarette?* which was developed by the American College of Obstetricians and Gynecologists and Smoke-Free Families.

Additionally, we recognize that those with serious behavioral health conditions die approximately 25 years earlier than the general population of tobacco users. Smoking prevalence among those with more severe forms of behavioral health conditions, such as schizophrenia, can exceed 80%.

Because of this, our behavioral health program provides enhanced tobacco cessation services to individuals who report having a behavioral health condition. Individuals contacting Quit for Life will be identified as potential participants for the behavioral health program through intake questions. Those who report schizophrenia or psychosis receive an invitation without a qualifier. Those who report other conditions are asked if they feel their concern is a barrier to quitting. If they respond affirmatively, these callers are invited to enroll in the program.

Tobacco Cessation – Quit for Life	
Populations who may receive the benefit	Enrollees 13 and older are eligible to receive this benefit.
Scope of benefit **Descriptions, where applicable** **Comparison to Louisiana Medicaid** **Procedure codes**	▪ **Description:** Enrollees have access to the Quit For Life program, the nation's leading tobacco cessation program. Enrollees will have access to five telephonic coaching calls (seven -10 calls for pregnant enrollees, including prenatal and postpartum stage; seven calls for enrollees with behavioral health conditions); personalized, interactive text messaging and anytime access to an interactive, mobile-friendly online website. ▪ **Comparison to Louisiana Medicaid:** Louisiana Medicaid covers tobacco cessation medications. The State sponsors the Louisiana Tobacco Quitline (1-800-QUIT) to promote the use of evidence-based tobacco cessation treatments, and this is a Medicaid Managed Care Quality measure in Louisiana. Promoting and providing an enhanced program will increase the success rate for our enrollees, with cumulative health and economic benefits for them. It will benefit those around them who may have been exposed to secondhand smoke. ▪ **Procedure Codes:** 99406, 99407
Proposed copayments	$0
How the benefit will be provided to enrollees	Our case managers screen all enrollees for tobacco use using the 12-item Short Form Health Survey (SF-12) and individual health needs assessment (HNA). Based upon the results from these screenings, care managers can provide information on and refer enrollees to the Quit For Life program. In addition, enrollees will receive outreach from the Quit For Life Program for inclusion in the tobacco cessation program. Enrollees can self-refer to the Quit For Life program. Pregnant enrollees who are identified with tobacco use may qualify as high risk and receive outreach from a Healthy First Steps (HFS) case manager who will connect them to this benefit.
Oversight of the value-added benefit	Our population health team, under the direction of Dr. Morial, oversees this benefit through review of reports that track participation, quit and satisfaction data, demographic information and self-referral. We do this to make sure enrollees who need the benefit have avenues to access them. Through the SF-12 assessment, we will educate enrollees verbally on the availability of the Quit For Life program. In addition, we will share the results of the SF-12 assessments with the Quit for Life Program so they can conduct outreach to those enrollees and make tobacco cessation reports available to LDH upon request.
PMPM actuarial value assuming enrollment of 350,000 enrollees	**$0.25**

Tobacco Cessation – Quit for Life	
Available for the 36-month term plus extensions	Yes
How this benefits our enrollees	▪ Improves health status and enhances quality of life ▪ Reduces the risk of premature death and can add as much as 10 years to life expectancy ▪ Lessens many adverse health effects, including poor reproductive health outcomes, cardiovascular diseases, respiratory issues, chronic obstructive pulmonary disease (COPD) and cancer ▪ Benefits people already diagnosed with coronary heart disease or COPD ▪ Benefits the health of pregnant women and their fetuses and babies ▪ Reduces the financial burden that smoking places on people who smoke, health care systems and society

2.6.3.1.5 Vision benefits for adults, including annual exam and glasses or contacts;

According to the CDC, more than 11 million Americans over age 12 need vision correction. Providing additional vision benefits to adult enrollees in Louisiana not only improves their overall quality of life and independence, but also enables early detection of other diseases like diabetes, multiple sclerosis and high blood pressure through eye examinations. In 2019, we covered vision benefits for over 14,000 enrollees.

We recognize the impact of visual health equity and the significance in providing enrollees with access to routine optical exams and services. Louisianans with severe vision impairment are more likely to have poor health outcomes, experience barriers to care, chronic conditions and mobility issues. Between 2018 and 2019, the enrollees who used their vision value-added benefits at UnitedHealthcare saw decreased inpatient admits and ED visits.

Vision Benefits for Adults	
Populations who may receive the benefit	Enrollees age 21 and older are eligible to receive this benefit.
Scope of benefit **Descriptions, where applicable** **Comparison to Louisiana Medicaid** **Procedure codes**	**Description:** Vision services including one routine eye exam **every year** and $100 allowance for frames and lenses and a $105 allowance for contacts every year. Using a whole-person approach, our case managers promote the vision benefit to support wellness and preventive health care. Case managers assist enrollees to access this benefit and encourage healthy outcomes. For diabetic enrollees, this benefit provides glasses and lenses in addition to existing coverage for eye exams available based upon diagnosis of diabetes. **Comparison to Louisiana Medicaid coverage:** Louisiana Medicaid does not provide coverage for vision services or allowances for frames and lenses for Medicaid-eligible adults. Procedure codes: 92015, 92065, 92071, 92072, 92311, 92312, 92313, 92314, 92315, 92316, 92317, V2020, V2025, V2100, V2101, V2102, V2103, V2104, V2105, V2106, V2107, V2108, V2109, V2110, V2111, V2112, V2113, V2114, V2115, V2118, V2121, V2199,V2200, V2201, V2202, V2203, V2204, V2205, V2206, V2207, V2208, V2209, V2210, V2211, V2212, V2213, V2214, V2215, V2218, V2219 V2220, V2221, V2299, V2300, V2301, V2302, V2303, V2304, V2305, V2306, V2307,

Vision Benefits for Adults	
	V2308, V2309, V2310, V2311, V2312, V2313, V2314, V2315, V2318, V2319, V2320, V2321, V2399, V2410, V2430, V2499, V2500, V2501, V2502, V2503, V2510, V2511, V2512, V2513, V2520, V2521, V2522, V2523, V2530, V2531, V2599, V2600, V2700, V2702, V2710, V2715, V2718, V2730, V2744, V2745, V2750, V2755, V2756, V2760, V2761, V2762, V2770, V2780, V2781, V2782, V2783, V2784, V2797, V2799
Proposed copayments	N/A
How the benefit will be provided to enrollees	Enrollees can access the benefit by visiting an in-network vision provider as provided through our vision subcontractor, MARCH Vision. We provide education on this benefit in our welcome packet and the *Enrollee Handbook*.
Oversight of the value-added benefit	We conduct monthly JOC meetings with MARCH Vision. During this call, we review compliance strategies and initiatives to support MARCH Vision's performance. This includes, but is not limited to, overall review of the business performance; assessment of key compliance and regulatory issues and risks; escalation of issues; review of FWA prevention efforts; discuss network adequacy; ensure recent complaints and grievances are resolved and monitor benefit utilization.
PMPM actuarial value assuming enrollment of 350,000 enrollees	$1.27
Available for the 36-month term plus extensions	Yes
How this benefits our enrollees	▪ Improved vision and vision correction ▪ Eye health ▪ Early detection of health-related issues

2.6.3.1.6 Identification and remediation of health-harming environmental factors related to an enrollee's shelter …

UnitedHealthcare's commitment to housing does not stop with finding enrollees a stable address. We are concerned with high-quality housing, including implementing a new assessment for our field-based case managers to probe into environmental factors that may impact a person's health. Our case management and support of these enrollees has led to a year-over-year decrease of 42% in average medical cost for lung disease due to external agents.

Lead Testing Teamwork

We recently learned of a Louisiana enrollee who was concerned her child was exposed to lead at daycare. Although she was expecting an elevated level, the Let's Get Checked (LGC) home lead test kit showed an alarming level of 39.07 ug/dl. Our LGC RN talked the mother through the test kit results and recommended immediate follow-up with the family's PCP. As a result, our enrollee learned the appropriate next steps from their family PCP and reported she was extremely appreciative of this program for helping her child. We confirmed that the LGC RN reported this issue to LDH for follow-up to the daycare.

Identification and Remediation of Harming Environmental Factors in Enrollees' Shelters	
Populations who may receive the benefit	All enrollees may receive remediation of health-harming environmental factors. Enrollees in case management with noted health concerns will be eligible for identification support.

Identification and Remediation of Harming Environmental Factors in Enrollees' Shelters	
Scope of benefit **Descriptions, where applicable** **Comparison to Louisiana Medicaid** **Procedure codes**	▪ **Description:** We offer multiple supports to identify and remediate health-harming environmental factors. For all enrollees using our Enrollee Services line, we assess their needs and provide linkages to community resources for home remediation and provide enrollees access to Aunt Bertha (soon Unite Us) for SDOH resources on the Enrollee Portal. These resources may include legal aid, temporary or permanent supportive housing, or other services appropriate to the enrollee's needs. If positively identified, the Member Services team works with case management and field-based staff to conduct monthly check-in visits to regularly assess and address environmental issues. ▪ For enrollees who have screened positive for health-harming risk through their PCP, we refer to community-based resources. ▪ If the enrollee in engaged in case management, our case manager looks for resources, evaluates if the enrollee is safe; and tries to determine if issue is the landlord's. If harm is self-induced or caused by neglect, our care manager refers the enrollee to Adult and Child Protective Services. ▪ For qualified enrollees in case management, we coordinate obtaining home lead testing kits (LetsGetChecked finger-prick test) and **home water testing kits**. ▪ **Comparison to Louisiana Medicaid:** Louisiana Medicaid does not provide coverage for identification and remediation of harming environmental factors in enrollees' shelters. ▪ Procedure codes: N/A
Proposed copayments	N/A
How the benefit will be provided to enrollees	During enrollment, enrollees receive printed tools for education and information to proactively avoid household environmental hazards. Whenever enrollees contact our Enrollee Services team for any reason, they are assessed for potential shelter-based concerns and connected via Aunt Bertha or Unite Us to SDOH resources. We coordinate this program through our case management and community health workers' (CHWs) training as an addendum to LDH's HNA to assess enrollees' needs around health-harming environmental factors. Member services, care managers and community health workers facilitate these services.
Oversight of the value-added benefit	UnitedHealthcare's case management team and Dr Morial
PMPM actuarial value assuming enrollment of 350,000 enrollees	$.02
Available for the 36-month term plus extensions	Yes
How this benefits our enrollees	▪ Decreased exposure to harmful factors ▪ Decreased risk to subsequent health issues, including learning disabilities ▪ Safer environment ▪ Decreased asthma and respiratory related ED visits and hospitalizations

2.6.3.1.7 Nonclinical home-based interventions for asthma such as home remediation, periodic and repeated…

Asthma impacts quality of life for many of our enrollees, including disproportionately high ED utilization due to pediatric asthma in East Baton Rouge. Through care management of this population, we achieved a decrease of 27.5% in acute care cost per enrollee with asthma between the fourth quarter of 2019 and the fourth quarter of 2020. We have maintained the lowest COPD and asthma admission rate in older adults among MCOs in Louisiana today (HEDIS rate of 30.95%, below the national 50th percentile of 37.76%). With this value-added benefit, we build upon this foundation to continue to engage our enrollees meaningfully.

Nonclinical Interventions for Asthma	
Populations who may receive the benefit	Enrollees with a pattern of asthma-related ED and hospitalization visits
Scope of benefit **Descriptions, where applicable** **Comparison to Louisiana Medicaid** **Procedure codes**	▪ **Description:** Our asthma disease management program will consist of a home assessment, action plan and associated interventions according to the individual's needs. Individuals can refer themselves or be referred by a provider or existing case manager for assessment. The case manager works with enrollee and PCP to establish an asthma action plan, including medication adherence and environmental interventions, such as: ▪ Asthma Kit, consisting of pillowcases and bed covers. Because exposure to dust mites is a common trigger in asthma, we will offer hypoallergenic mattress covers and pillowcases to help reduce or eliminate dust mites for enrollees under active case management for asthma. ▪ Our Quit for Life program, described in Section 2.6.3.1.4 for Tobacco Cessation, above will conduct targeted outreach to enrollees with asthma, for whom smoking or in-home tobacco use may be a contributing factor. • **Comparison to Louisiana Medicaid:** Louisiana Medicaid does not provide coverage for nonclinical interventions for asthma. • Procedure codes: N/A
Proposed copayments	$0
How the benefit will be provided to enrollees	Enrollees will be identified for this program based upon trend analysis for high utilization due to their asthma diagnosis. Along with proactive outreach by email to asthmatic enrollees, case managers will offer home visits to assess the enrollee's environment and suggest appropriate benefits to the enrollee. Hypoallergenic mattress covers and pillowcases are offered by a case manager to enrollees who have a history indicating poorly managed asthma. Our case manager will also make referrals to the Quit for Life program to establish these connections as appropriate.
Oversight of the value-added benefit	Dr. Morial and the case management team
PMPM actuarial value assuming enrollment of 350,000 enrollees	$0.004
Available for the 36-month term plus extensions	Yes

Nonclinical Interventions for Asthma	
How this benefits our enrollees	▪ Identify and address triggers ▪ Decreased related ED visits and hospitalizations ▪ Improved overall health and quality of life ▪ Increased number of healthy/well days ▪ Better breathing

2.6.3.1.8 Comprehensive, evidence-based, longitudinal home visiting programs (for example, Nurse Family …

According to the 2020 March of Dimes Report Card, Louisiana had a 13.1% preterm birth rate and Black women are 55% more likely to experience a preterm delivery. Additionally, access to community health workers and home visiting were among the key recommendations within Louisiana's Medicaid expansion to impact maternal health.

The Louisiana Department of Health and the Louisiana Perinatal Quality Collaborative (LaPQC) are committed to reducing maternal morbidity in the State. Maternal and infant health outcomes are a key priority area for us, as reflected in our 2020 commitment of over $275,000 in grants to support statewide maternal health-related CBOs.

Advance Health Equity

Our historical commitment has shown the following results: from 2018 to 2019, we saw results in our HEDIS measure for postpartum care (PPC) among all enrollees, including a 13% improvement in timeliness of prenatal care and a 19% improvement in postpartum care among Black enrollees. This translated to a decrease in the disparity between Black and white enrollees. In addition, we are ranked highest in postpartum care, timeliness of prenatal care, and percentage of low birth weight HEDIS quality measures across all MCOs in Louisiana in 2020.

We are committed to individualizing perinatal support with our existing Healthy First Steps (HFS) case management and investment in a doula partnership with Birthmark, which leverages a home visiting model to new moms and young families with children up to 1 year of age access. Our HFS home visiting staff will receive training based upon the Healthy Start evidence-based curriculum and program. Home visiting is based upon the targeted case management (TCM) approach, which will assist enrollees in gaining access to medical, social, behavioral health, educational programs, and other services. Our HFS team will provide assessment services, develop a care plan, assist enrollees with referrals and scheduling, and monitor and follow-up, to enrollees who opt in to the home visiting program. If participating families need additional services, our case manager works with enrollees to connect them to other local organizations.

Comprehensive, Evidence - Based, Longitudinal Home Visiting Programs for Pregnant and Postpartum Enrollees and Their Newborns	
Populations who may receive the benefit	Women who are identified as pregnant or who have recently delivered
Scope of benefit **Descriptions, where applicable** **Comparison to Louisiana Medicaid** **Procedure codes**	▪ **Description:** We offer connection to and coverage for community-based home visiting programs like Nurse Family Partnership, Healthy Start, Parents as Teachers or other evidence-based programs. We will cover a per-visit or per-episode rate, to be agreed upon with each entity. Enrollees engaged by one of these programs will receive evidence-based support and interventions with an aim of two visits pre-birth and two visits post-delivery. Expecting mothers, particularly those considered at-risk, and families receive an assessment in their

Comprehensive, Evidence - Based, Longitudinal Home Visiting Programs for Pregnant and Postpartum Enrollees and Their Newborns	
	home for safety and health determinants. The goal of the program is to help give the necessary resources and skills to raise children who are physically, socially and emotionally healthy and ready to learn. ▪ **Comparison to Louisiana Medicaid:** Louisiana Medicaid does not provide coverage for these services. ▪ **Procedure codes:** N/A
Proposed copayments	N/A
How the benefit will be provided to enrollees	We identify eligible enrollees through multiple channels, including regular claims review for all women of child-bearing age, referrals from providers, community-based organizations, or enrollees and their families; and our HNA process. Enrollees are connected to available home visiting programs by our Healthy First Steps case management team. Enrollees may reach out directly to the home visiting programs if interested, and the home visiting programs will share this information with us to make sure coverage and communication about the enrollees is put into place.
Oversight of the value-added benefit	Our Healthy First Steps manager and Dr. Morial will provide oversight of this benefit and make sure high standards are being met through our home visiting partners.
PMPM actuarial value assuming enrollment of 350,000 enrollees	$0.12
Available for the 36-month term plus extensions	Yes
How this benefits our enrollees	▪ Improves maternal and child health ▪ Reduces incidences of child abuse and neglect ▪ Improves birth outcomes ▪ Decreases pre-term births and low-birth weight ▪ Improves school readiness for children ▪ Allows assessment of environmental space and identification of needs or specific requests of our enrollees

In summary, we offer value-added benefits to encourage healthy behaviors and break down barriers that lead to improved health outcomes. Offering services that enhance equity in outcomes enable enrollees to feel empowered while taking personal responsibility for their health and wellness.

2.6.3.2 LDH reserves the right to add additional options during the term of the contract, and the selected Proposer …

UnitedHealthcare understands LDH may add additional options during the term of the Contract. We understand that individuals enrolled in Medicaid are disproportionately affected by environmental, social and economic challenges that present significant barriers to managing their health; thus, we continuously monitor, evaluate and foster innovation to build and scale our population health programs that reflect the populations we serve. Our population health focus continues to inform our approach to value-added benefits, enhancing equity in health outcomes and supporting our preventive health program. We share information and receive feedback on these value-added benefits from organizations, including the Enrollee Advisory Council, Health Equity and SDOH Advisory Council, Member Services and other trusted sources.

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Attachment 2.6.3.4 Actuarial Statement

2.6.3.4 For each selected value-added benefit, the proposal should indicate the PMPM actuarial value of benefits on a per member basis, assuming an enrollment of 350,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.

I, Kevin Francis, am a member of the American Academy of Actuaries and meet its qualification standards for Statements of Actuarial Opinion. I have examined the actuarial assumptions and actuarial methods used in setting the expanded benefits rates for the entire thirty-six month term of the initial contract term of 36 months.

In my opinion, the value-added benefits rates are actuarially sound, have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I have relied upon the historical claim data for eligible enrollees, program eligibility data, internal UnitedHealthcare experience from other markets, as well as reasonable actuarial judgement. Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as delineated by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Signature: 

Kevin Francis, FSA, MAAA

Chief Actuary, UnitedHealthcare Community & State

Summary of Value-Added Service Commitments

Value-Added Benefit	PMPM Commitment (PMPM actuarial value assuming enrollment of 350,000 enrollees)
[redacted]	

2.6.4 Population Health [12-page limit]

2.6.4.1 The Proposer should describe its approach to, and experience with, improving population health for …

Our Experience Improving Population Health in Louisiana

Achieving meaningful population health improvement for our more than 500,000 Louisiana enrollees, their families, and communities, requires us to go beyond the traditional HEDIS® and utilization management centered approach. Our population health improvement strategy is core to health care delivery and leverages person-centered, medical, and behavioral integrated solutions to address enrollee needs at all points of the care continuum and incorporates a focus on disparities and social determinants of health (SDOH).

#1 in Louisiana
Since 2016, UnitedHealthcare has been the top performing Louisiana Managed Care Organization for annual quality performance measures as defined and documented in the LDH Quality Dashboard.

With more than 40 years of experience improving population health for Medicaid populations nationally, we have served Louisiana Medicaid enrollees since 2012. Our locally based **Integrated Population Health Quality Team** has more than **120 years** of combined experience applying population health principles. Population health improvement extends beyond this team, with organization-wide engagement and collaboration with enrollees, providers, community-based organizations (CBOs) and other MCOs for a collective impact. We have achieved improved outcomes and at the same time recognize that more work remains to improve the health of all Louisianans by mitigating disparities and addressing root causes of gaps in care and disease.

Demonstrated Population Health Improvement: Maternal Child Health

Our approach to empowering birthing people in their care, evolving the health system to better support pregnant enrollees, and thoughtfully engaging communities in birth equity efforts has resulted in a 7.7% improvement in low-birth-weight rate among our Louisiana enrollees, from 12.47% in 2018 to 11.51% in 2020, the lowest rate of all Healthy Louisiana MCOs. In HEDIS measurement year 2019, we led the MCOs with the best outcomes in 5 of the 9 Maternal Child LDH Quality measures.

Our Approach to Improving Population Health in Louisiana

Our approach to measuring and improving population health outcomes and advancing health equity is based upon the Institute for Healthcare Improvement (IHI) Model for Improvement. We follow a **four-step iterative process,** as shown in the figure. This includes using **data** to analyze root causes and key determinants; thoughtful **engagement** of enrollees, providers and CBOs in **intervention identification, design and implementation;** and leveraging the IHI plan-do-study-act (PDSA) method and best practices in quality improvement (QI) science to **evaluate outcomes** and continuously improve our approaches. We apply these processes and core population health principles such as evidence-based practice, innovation, person-centered design, and a culture of

continuous QI across **all** departments in our organization, as described in Section 2.6.4.1.4, to inform and guide our managed care program in Louisiana.

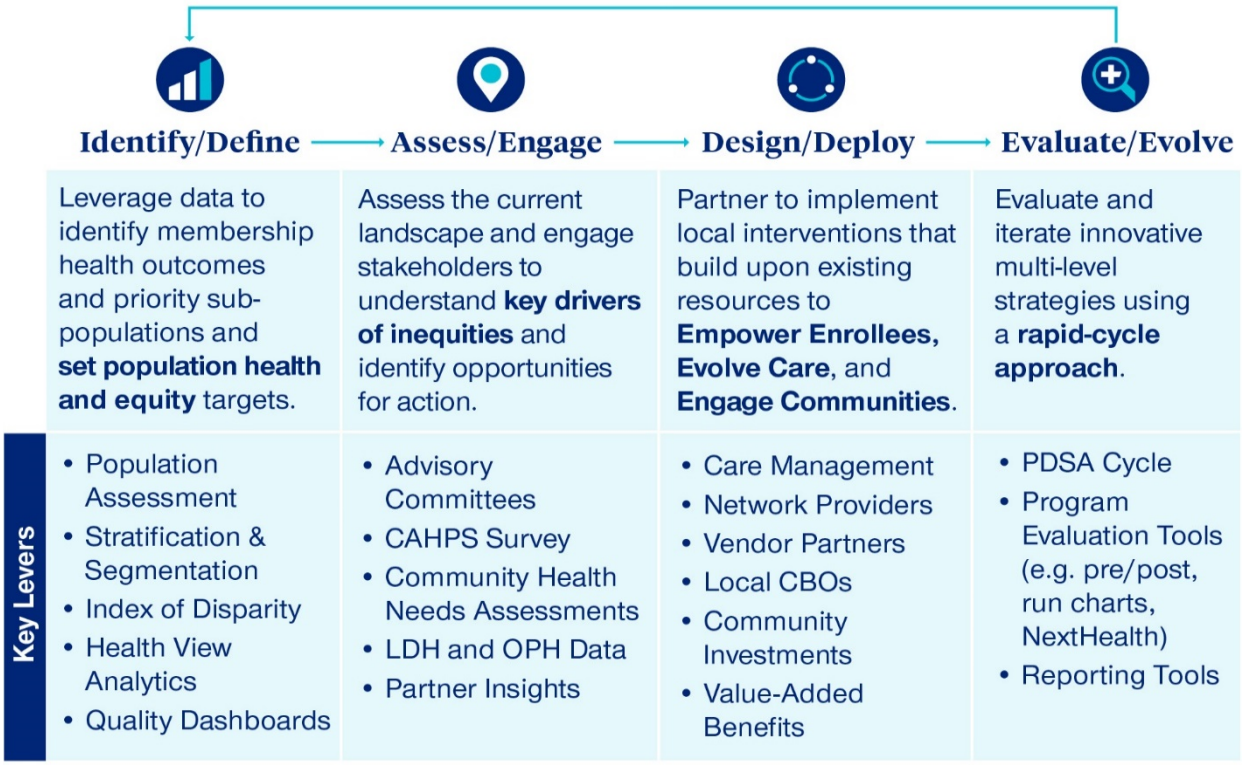

Figure 8. Population Health and Equity Approach. We use this approach to improve health outcomes and equity.

2.6.4.1.1 Identifying baseline health outcome measures and targets for health improvement;

Identifying and Defining Baseline Measures and Targets for Improvement

We begin by establishing overarching strategic population health goals tied directly to the Louisiana Medicaid Managed Care Quality Strategy to help meet and exceed LDH's Triple Aim focus on **better care, healthier people and healthier communities with smarter spending,** as shown in the figure.

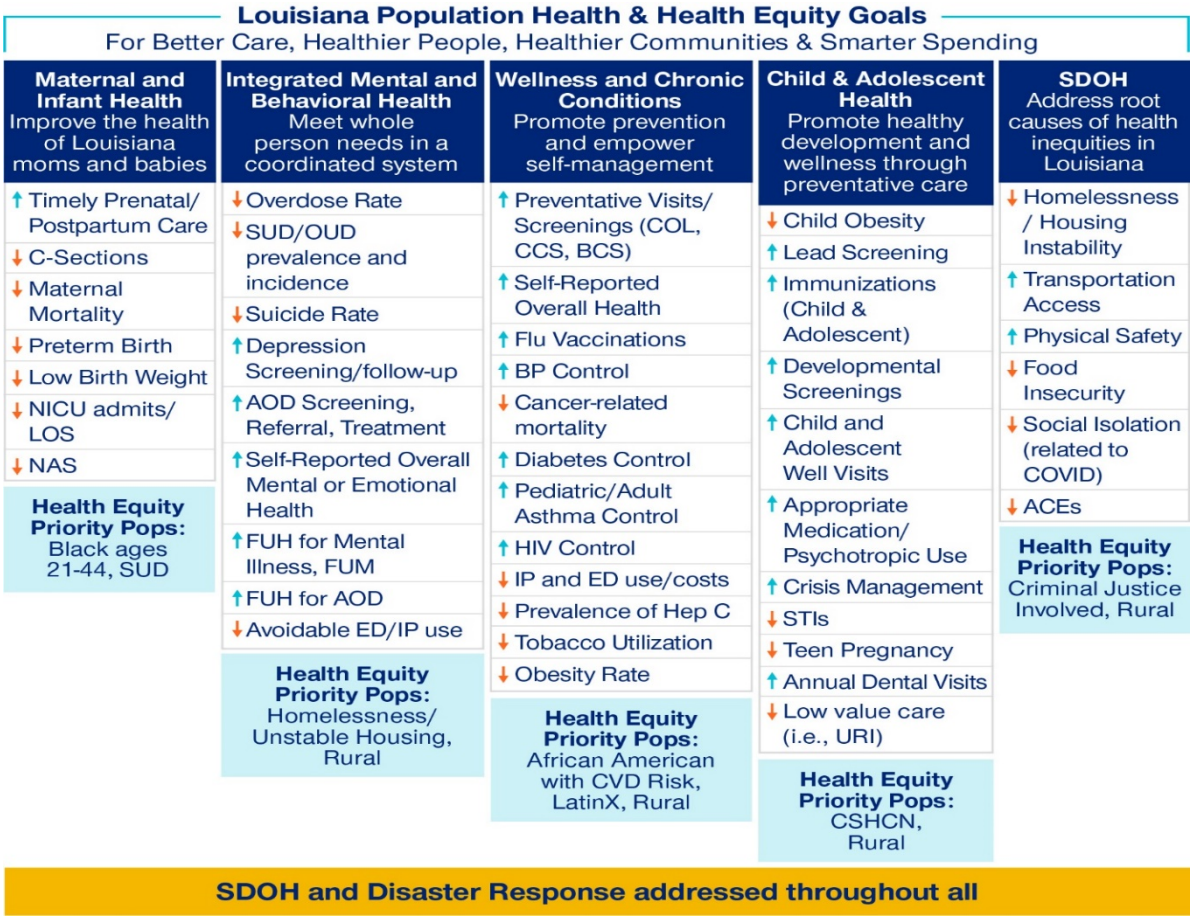

Figure 9. UnitedHealthcare Community Plan of Louisiana Population Health & Equity Strategic Goals. Focused on providing better care, healthier people and healthier communities with smarter spending.

Our strategic goals are informed by the major health care needs, key public and population health challenges, and priority subpopulations in Louisiana. For each population health priority, we further define global aims, Specific, Measurable, Achievable, Relevant, Time-bound (SMART) aims, and a pragmatic subset of measures to assess baseline performance and set targets, including, but not limited to, measures defined in the Model Contract Attachment H. An example is shown in the table.

Global Aim	SMART Aim: 2019 Baseline & 2020 Improvement Target	Result
↑Diabetes control and self-management	Increase the percentage of enrollees with HbA1C < 8.0% by 2 percentage points, from 41.12% to 43.12%, by Dec. 31, 2020	Achieved 50.63% HbA1C Control, a 9.51 percentage point improvement, exceeding goal

We set performance thresholds for ourselves and providers tied to our strategic goals and monitor performance using relevant nationally recognized metrics

2.6.4.1.2 Measuring population health status and identification of sub-populations within the population;

Measuring Population Health Status and Identifying Subpopulations

Advance Health Equity

Advancing health equity is foundational to our population health approach. We think critically about why some populations experience better health outcomes than others. We measure population health

status at the population level within each of our identified population priorities and stratified by key enrollee characteristics to identify subpopulations of focus.. As part of our Multicultural Health Care Distinction efforts, we conduct disparity analyses using stratified data and the nationally validated Index of Disparity (ID).

For example, we analyzed data from LDH on COVID-19 vaccinations by race/ethnicity and found an ID of 19.4%, with the lowest rate among white enrollees, particularly in the Northern part of the state. We established a SMART Aim and conducted quantitative and qualitative analyses to understand drivers of this gap, such as hesitancies related to religious views. We then developed partnerships with the **Catholic Diocese in Shreveport and the Greater Zion Baptist Church** to conduct vaccination education and outreach and partnered with Shreveport HUD on six community vaccination events. We will evaluate success in reducing the ID in Q4 2021.

In our assessment of health status among our pregnant population, we found that Louisiana's teen birth rate of 27.8 births per 1,000 women is the third highest in the country. Using our Health View Analytics tool, we identified rates of preterm birth among enrollees aged 14 to 17 as high as 100% in certain ZIP codes, largely concentrated in Caddo Parish. To address this need, we partnered with the **Children's Coalition for Northeast Louisiana** to host reproductive health sessions in six schools. We provided a **$50,000 grant to Common Ground Community** in Shreveport to enhance reproductive education for girls age 11-18 **(taught by our medical director, Dr. Glenda Johnson**). In April 2021, our Healthy First Steps case management team implemented a pregnant teen assessment to understand unique needs and provide tailored supports, such as referral to a school counselor for job readiness or support with Nurse Family Partnership enrollment.

2.6.4.1.3 Identifying key determinants of health outcomes and strategies for targeted interventions to reduce…

Assessing and Understanding Key Determinants of Health Outcomes

We leverage root cause analysis, data analysis and stakeholder engagement to identify specific drivers at play. With enrollee, provider and community insights, we validate our analytic findings, refine our understanding, and determine needs and assets in the community and system of care. Example data sources and processes to identify determinants of health outcomes include:

- **Social determinants of health and community factors:** Community Health Needs Assessments, County Health Rankings, Area Deprivation Index, enrollee SDOH data; State and community input via local relationships, Health Equity & Collaborative Council; state-declared emergency locations during disasters
- **Delivery system factors:** Provider-level quality data, integration of medical and behavioral health, length of stay and 30-day readmission data, appointment availability and general access to care (especially for specialists and behavioral health providers), provider ability to deliver trauma-informed care and access to culturally appropriate care
- **Enrollee health behaviors and beliefs:** Claims and ICD-10 Z-code analysis, grievances and appeals data, enrollee surveys, listening sessions, Enrollee Advisory Council

As Louisiana residents, we are acutely aware of the impact of **climate-related events** on vulnerable populations, magnifying disparities in health outcomes. We integrate disaster response in our population health strategy, conducting targeted outreach to at-risk enrollees and providing community support, such as **$500,000** to the **Community Foundation of Southwest LA** within a few days after impact for hotels, respite, clothing, food and water during Hurricane Laura.

Design and Deploy Strategies and Targeted Interventions to Reduce Disparities

Equipped with data and enrollee and community insights, we collaborate with partners, including providers, CBOs, and LDH, to identify, develop and deploy interventions to reduce disparities. Designing with equity in mind influences **where, how, and who** deploys an intervention to reduce gaps in care. Underlying causes are often complex, so we work with local partners to consider what can be done at multiple levels **— community, health system, organizational and enrollee —** to reduce disparities and improve the health of the entire community. We leverage and promote **evidence-based** programs and practices and incorporate stakeholder input in our intervention design. Recent strategies and targeted interventions are described in the tables below, in alignment with our strategic goals.

Community Wellness Centers
UnitedHealthcare has invested in **four Wellness Centers**. These centers will bring preventive care, telehealth access points, education, digital access to benefits and other health and social resources to our enrollees directly into their neighborhoods. The first center is scheduled to open in Baton Rouge by October 2021. We will have two centers in New Orleans (on the East and West Bank) and another in Houma/Thibodaux area by the end of 2022. We are exploring adding nurse practitioners to each center to work face-to-face with our enrollees to support prevention and wellness.

Population Health Strategic Priority: Wellness and Chronic Conditions

Strategies & Interventions to Promote Prevention & Empower Chronic Disease Self-management	
Cardiovascular Disease and Hypertension Pilot *Global Aims:* ↑BP Control ↓IP/ED use ↓Racial Disparities	More than 55,000 of our Louisiana enrollees have hypertension, making it one of the most prevalent conditions in our population. Our internal **Hypertension Task Force** reviews trends to identify opportunities for action. We found that our Black enrollees are 1.4 times more likely to have hypertension than white enrollees. We are working with targeted providers serving 7,000 of our Black enrollees on an evidence-based "Tuck-in" program. Enrollees receive 1:1 weekly outreach from a PCP office care coordinator to check vitals (e.g., blood pressure), medication adherence, diet and exercise, and connect to needed services and supports. A provider's initial result found enrollee **ED utilization fell by 42% and inpatient hospitalization by 72% post-engagement.**
Diabetes Wellness Days *Global Aims:* ↑Diabetes Control ↓IP/ED use	More than 25,000 enrollees have diabetes and nearly 10% reside in Orleans Parish. We are working with **DePaul Community Health in New Orleans** to promote self-management and address regional disparities in Comprehensive Diabetes Care (CDC), including HbA1C, eye exams and medical attention for nephropathy. Wellness Days include education on HbA1C levels, lipid panel lab results, using a glucose monitoring machine, nutrition and meal planning, and exercise. Wellness Days screen for depression, stress management support and referral to behavioral health services.
Remote Patient Monitoring *Global Aims:* ↓Maternal Morbidity ↑BP Control ↑Diabetes Control ↓Racial Disparities	We track Severe Maternal Morbidity (SMM) by race/ethnicity among our enrollees and found the 2019 SMM rate was 1.7 times higher among Black enrollees compared to white enrollees, increasing risk for poor birth outcomes and maternal mortality. To address this disparity, in 2020, we supported **LCMC and Tulane**, serving high volumes of Black pregnant enrollees, with adopting the **Babyscripts digital educational app and remote patient monitoring (RPM) modules** for hypertension and diabetes. We are launching an RPM diabetes management pilot for eligible diabetic enrollees to address disparities in diabetes control. Our RPM vendor will offer remote monitoring and coaching for when issues are detected. The program includes app-enabled engagement and education for diabetes management, including a cellular connected scale and weight and glucose monitoring.

Our multi-level efforts to improve chronic condition self-management resulted in significant improvements in HEDIS rates, including a **19-point improvement in Controlling blood pressure (from 37.96% in MY2016 to 57.42% MY2019)**. Building on this work, our **health equity-focused Gap Closure VBP** program will specifically incentivize providers to reduce disparities among disparate populations for key population health measures.

Population Health Strategic Priority: Integrated Mental and Behavioral Health

Strategies & Interventions to Meet Whole-person Needs in a Coordinated System	
Reducing Admissions with Collaborative Interventions (RACI) Program ***Global Aims:*** ↑FUH ↓IP Readmits	RACI is an interdisciplinary collaborative approach to address disparities in behavioral health outcomes by decreasing acute behavioral health readmissions and increasing community tenure for individuals with complex needs. Implemented in 2020 with **Brentwood Hospital, River Oaks Hospital, Covington Behavioral Health, and Odyssey House**, RACI improved communication with inpatient staff, proactive identification and management of needs, and provider relationships and eliminated silos of care. We have seen a **48% improvement in 30-day readmit rates, 30% improvement in 90-day readmit rates and 18% improvement in 90-day community tenure** among engaged enrollees. We are expanding RACI in 2021-2022.
Genoa Embedded Pharmacies & Medication Management ***Global Aims:*** ↑FUH ↓IP/ED use	More than 32% of our enrollees have comorbid physical and behavioral health needs. In collaboration with 10 Louisiana Genoa Healthcare pharmacies, we provide medications at the time of discharge, close gaps in care evident by high utilization of inpatient services, identify enrollees at risk of medication non-adherence, and monitor and optimize the medication regimen of high-cost enrollees using comprehensive medication management services. Genoa is involved with our value-based payment shared savings arrangement for medication adherence and follow up after hospitalization. The Comprehensive Medication Management program launched in Louisiana in September 2020. **As of May 2021, 4,137 enrollees qualified and 47% of those reached have been engaged in the program.**

2.6.4.1.4 How required components of this procurement and other Proposer developed initiatives are integrated, …

How Required Components and Initiatives are Integrated

Improving the health of our enrollees is at the center of everything we do, as shown in the figure, with a culture of improvement engaging all parts of our organization. Our strategy includes shared accountability for population health and health equity outcomes across clinical, network and operational areas. Leadership team led by our CEO Karl Lirette, empower cross-functional teams to identify key determinants of health and take needed action. Engaged staff include field-based quality, population health, UM, and integrated case management teams. Each function considers how their interactions with enrollees, providers and other stakeholders integrate to achieve our population health and equity goals, with regular reporting to leadership on progress.

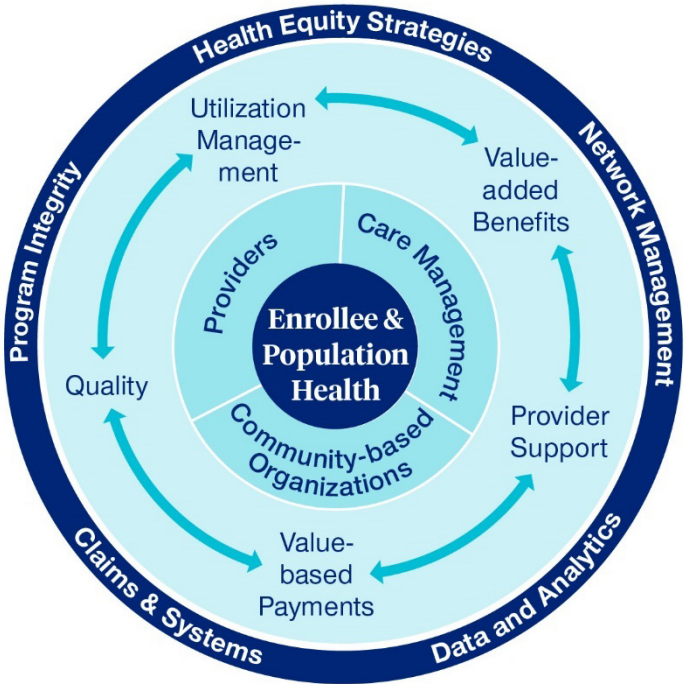

Figure 10. Louisiana Ecosystem to Improve Enrollee and Population Health. We employ a collaborative, unified approach across our organization to improve the health of our enrollees within the complex health care delivery system.

2.6.4.1.5 Other considerations the Proposer may seek to present.

Other Considerations in Our Population Health Strategy

Our population health strategy is designed to empower enrollees in their care, evolve the delivery system, and engage and support communities in addressing root causes of health inequities. In addition to the approaches described above, our focus includes:

- **Enrollee incentives to empower wellness and prevention:** Includes HNA completion, annual adult wellness visits, and timely completion of prenatal and postpartum appointments and well-child visits. We have found pregnant/postpartum enrollees in our Maternal and Child Health program; **Healthy First Steps Rewards program attend 14% more physician visits and have a 5.7% lower rate of ED use than nonparticipants**.
- **Advancing medical-behavioral and social integration:** Communication and coordination between behavioral and physical health care providers is essential for our nearly 160,000 enrollees with comorbid physical and behavioral needs. Our strategic goals include measures focused on improving behavioral health outcomes, while incorporating an integrated lens across all our programs. For example, recognizing the impact of Adverse Childhood Events (ACEs) on child health and development, we will have a **certified ACEs educator** on our team to expand provider training on the impact of ACEs and trauma on health outcomes. We implemented **an Enhanced Integration Initiative** to support behavioral health and physical health providers in moving up the integration continuum, and integrate behavioral health into our VBP programs, such as our **MAT Retention Incentive** program.

2.6.4.2 The Proposer should describe what it will do to address population health in the first year of the contract, …

Milestones and Time Frames to Address Population Health

Building on our current efforts, we propose key milestones and time frames to address population health in the first year of the new contract outlined in the table. A written project plan is part of our readiness review and implementation activities. We look forward to continuing to work closely with LDH, enrollees, providers and key stakeholders to evolve our population health strategy.

Key Milestones to Address Population Health *(Model Contract Alignment)*	Time Frame
Expand provider knowledge/understanding of SDOH, cultural competency and implicit bias with additional provider training opportunities *(Model Contract 2.6.1.3)*	Q2 – Q4 2022
Expand existing enrollee prevention, wellness and issue-specific programs (e.g., Hypertension Tuck-in, Diabetes Wellness Days, Wellness Centers) *(Model Contract 2.5.1.2)*	Q2 – Q4 2022
Hire/train Health Equity Administrator and integrate Health Equity Plan with Population Health Strategic Plan *(Model Contract 2.5.1.10)*	Q1 – Q4 2022
Incorporate new LDH-HNA results into our SDOH Data Registry; collaborate with LDH, providers, CBOs and other MCOs to increase HNA completion *(Model Contract 2.5.1.4)*	Q4 2022
Expand Enrollee Advisory Committee membership to include enrollees with disparate outcomes and incorporate input in QI initiatives *(Model Contract 2.6.1.2.3)*	Q3 2022 – Q4 2022
Expand relationships and contracting with CBOs and Office of Public Health programs to address whole-person needs, including SDOH *(Model Contract 2.5.1.6, Model Contract 2.5.1.7)*	Q3 2022 – Q3 2023
For all above strategies: evaluate outcomes, evolve through rapid-cycle approach, continue successful programs, revise for continuous ongoing improvement, and develop/submit Annual Report to LDH *(Model Contract 2.5.2)*	Q3 2023

We will meet with LDH, upon receipt of the award and use their guidance to enhance our milestones and timelines for completion in our first year of the contract.

2.6.4.3 The Proposer should describe its recent experience with utilizing data regarding social determinants of…

Experience and Approach Using SDOH Data to Improve Health Equity

We collect and use SDOH data from internal and external sources to understand needs, inform strategy, and target our interventions and community work. We routinely analyze SDOH measures (e.g., % homeless/unhoused, % food insecure) at the community and enrollee levels using both publicly available and aggregated enrollee data, as shown in the figure. Our leadership can identify patterns of social needs across our enrollee population in the context of community and regional SDOH needs to inform our overall population health and health equity goals and strategic planning.

Figure 11. Using SDOH Data to Inform Strategy. Example analyses of community-level SDOH measures to understand SDOH at regional and statewide levels and inform health plan strategy across multiple departments. Sourced through our SDOH national registry with data points around claims, NA and SDOH referral platform.

Our clinical and population health quality teams use community and enrollee data to assess SDOH needs as underlying drivers of health disparities among priority subpopulations and incorporate needed supports into intervention selection and design.

SDOH Data Collection

Sources of SDOH data include those noted below. Data is integrated into our national **SDOH registry** with monthly reporting on utilization and top resource needs among our enrollees.

- **Claims (ICD-10 Z codes):** We are implementing an SDOH incentive pilot to increase provider screening and reporting of enrollee SDOH needs using ICD-10 Z codes.
- **Enrollee Health Needs Assessments (HNA):** Conducted via enrollee touchpoints (e.g., enrollee services, care management, CHW outreach) and tracked in our care management platform, our HNAs assess for SDOH (e.g., housing, food insecurity, transportation).
- **Our SDOH Resource and Referral Platform:** We currently use the Aunt Bertha platform to search for resources and refer enrollees. We are expanding our capabilities to enable **closed loop referrals and tracking by transitioning to the Unite Us platform** which includes on-the-ground resources and CBO network development, to launch before contract go-live.

Our geo-mapping tools integrate SDOH data, such as the "% Members with SDOH Markers" indicator in Health View Analytics to identify regions, down to the ZIP level, with high prevalence of SDOH needs. We contextualize data through stakeholder input to understand barriers and infrastructure needs via forums such as our Enrollee and Provider Advisory Committees.

Example: Using Data to Address Homelessness and Housing Instability

Identify/Define: Regional-level data from County Health Rankings in the figure above indicated severe housing problems as a key challenge in Louisiana, particularly in Region 1. We saw this need reflected using our Hotspotting tool, which identifies possible homelessness or housing instability by integrating data from sources such as claims, enrollee contact information and documentation from case managers. As many as 2,000 of our enrollees have been identified as homeless, with higher concentrations in New Orleans and Baton Rouge.

Assess/Engage: The Hotspotting tool assesses clinical risk factors among housing unstable enrollees to understand potential drivers and subpopulations disproportionately experiencing homelessness. We found that 87% of housing unstable enrollees have behavioral health needs, with top primary diagnoses of psychotic/schizophrenia disorders, substance use, major depressive disorder and diabetes making housing instability a critical issue requiring an integrated approach.

Design/Deploy: Leveraging data insights, we implemented several initiatives to address the complex challenge of housing instability. In alignment with our population health approach, our multi-level strategy includes **empowering enrollees to secure permanent housing**, **evolving care to better integrate housing supports with primary care and behavioral health, and engaging communities in expanding affordable housing,** as described below**.**

- **Empower Enrollees:** In 2019, we hired a dedicated housing liaison to lead our Housing Solutions Program and consult with our care management teams for enrollees experiencing housing, utilities and infestation issues. Ms. Griffin meets with enrollees to track and assess progress, identify barriers, and troubleshoot solutions, including providing referrals to transitional housing, Section 8 vouchers, or the state's Permanent Supportive Housing

program. Ms. Griffin directly supported more than 20 enrollees in securing stable housing, with an average **73% reduction in ED visits** from 2019 to 2020 among those housed in 2019.

Enrollee Success Story: Housing Support for Ms. Ross and Her Family

During the COVID-19 pandemic, Ms. Ross, a bed-bound enrollee with complex illnesses, along with her family of five, were threatened with eviction from her home. In addition to her lack of appropriate environmental and ADA access, she and her family also faced other SDOH issues. We connected Ms. Ross to community-based services to assist with food, clothing, school enrollment and coordination to needed medical care. With the help of our housing liaison, Catina Griffin, RN, we secured affordable housing for Ms. Ross and her family just in time for Christmas.

- **Evolve Care:** Through our UnitedHealthcare Catalyst™ collaborative initiative with Open Health Care Clinic (OHCC) in Baton Rouge, we helped to integrate housing supports with primary care and behavioral health care. Between April and July 2021, an OHCC behavioral health care manager placed at One Stop Homeless Center successfully served 64 persons experiencing homelessness, including assessed mental health needs, referred to primary care and behavioral health services, and assisted with applications for housing assistance and nutritious food.
- **Engage Communities:** UnitedHealthcare invested $17.9 million since 2019, **providing $11.5 million in bridge financing to Louisiana Housing Corporation** and **$6.4 million to Renaissance Neighborhood Development Corporation** to develop a 122-unit apartment complex for low-income veterans, families and persons with disabilities in Valencia Park of Spanish Town. During the pandemic, which has further exacerbated housing instability, we **provided $250,000 to Covenant House New Orleans** for food, clothing, shelter, medical attention, counseling, and job placement for homeless youth in communities most in need — Gert Town and the Ninth Ward — based upon input from the New Orleans Health Department and state health leaders.

Evaluate/Evolve: To assess the impact and continuously improve our interventions, we track process measures (e.g., # and % of enrollees reached/engaged) and outcome measures (e.g., # individuals/families housed, pre/post utilization). Nationally, we found the approaches applied in Louisiana have led to a **statistically significant (35%) decrease in total cost of care among our housing-insecure enrollees**, driven by decreased inpatient utilization with increased physician visits. In August 2021, we launched a **$220,000 initiative to expand our Housing + Health model** in partnership with the Ozanam Inn. This program will provide enrollees room and board, intensive case management and life skills training for three to four months (or longer, if needed) while Ozanam works to secure permanent housing. **UnitedHealthcare is committing $100,000 and leading a collaborative effort of CBOs, the National Health Care for the Homeless Council (NHCHC), and multiple providers to create the first NHCHC-accredited Medical Respite**

"Ozanam Inn is extremely grateful for our partnership with UnitedHealthcare and the time, effort, and considerable energy they have put into each aspect of the collaborations between our two organizations to aid and assist the homeless population in our community. **UnitedHealthcare continues to be an invaluable partner with Ozanam Inn in our mission to reduce health disparities and end homelessness."**

- Renée B. Blanche, Ozanam Inn Deputy Director/Director of Development

facility in the state. Set to open in New Orleans in October 2021, it will provide accessible accommodations (e.g., bed, shower, laundry, secure storage, three meals per day), onsite primary medical, dental and behavioral health services, care coordination, housing navigation and integrated wraparound social support services.

Applying Our Approach to a Key Population Health Priority

We **identified** maternal morbidity and mortality as a top priority in alignment with Model Contract 2.5.1.2.2, given Louisiana's maternal mortality rate of 58.1 deaths per 100,000 births is the highest in the United States. To **assess** drivers of disparities in maternal morbidity, mortality and birth outcomes, we conducted listening sessions among low-income moms of color, with 82% of participants stating that financial concerns impacted them during pregnancy and after childbirth, highlighted by expressed fears about affording necessities such as food. Through our partnership with Mom's Meals, we **deployed** an intervention to provide home-delivered meals (two meals a day for 30 days during pregnancy and two weeks postpartum) to enrollees experiencing food insecurity. In 2020, we provided a total of 6,800 meals through Mom's Meals. Through pre/post **evaluation,** we found a **36% decrease in low-acuity, non-emergent ED visits** among food insecure pregnant enrollees post-engagement in care management. To build the capacity of organizations serving the broader SDOH needs of moms and families, we provided $275,000 in grant funding and developed coordination processes with seven organizations across Louisiana, including Saul's Light which offers financial assistance to families in need. We are continuing to **evolve** our strategy by testing incentives for screening for social needs (including food insecurity) in our Gap Closure VBP to increase identification and connection to services.

2.6.4.4 The Proposer should describe its approach to engage providers, enrollees, and families, and to contracting …

Engagement Approach to Coordinate Population Health Improvement

We are only one part of the system, so we highly value and proactively seek opportunities to engage all stakeholders, in alignment with LDH's guiding principle of "*Nothing About Me, Without Me*." To achieve this, our senior leadership and on-the-ground engagement teams cultivate ongoing, transparent relationships with individual enrollees and families, providers, OPH, CBOs, advocacy groups, schools, faith-based organizations, and local social service agencies and programs as vital partners in our work. We encourage a **culture of authentic community engagement and** participation throughout our organization, starting with our executive leadership team. Executive leaders serve on numerous local boards and engage with providers, enrollees and families through one-on-one meetings, community events and council meetings. In 2021, we established a **Health Equity & SDOH Collaborative Council** of community leaders across the state to engage in information-sharing, collaboration and co-creation of community-based solutions.

Our team includes **field-based community health workers (CHWs)** who live and work in the communities we serve, engaging enrollees on a local level. They build strong working relationships with CBOs and providers to collaboratively address whole-person needs. We leverage our 40 locally based, provider-facing consultants, advocates and network teams who build supportive relationships with physical, dental and behavioral health providers, hospitals and EDs across Louisiana, including federally qualified health centers (FQHCs) and community mental health centers (CMHCs). Drawing upon our organizationwide, deep, personal relationships with providers, enrollees and communities, combined with our analytic capabilities to pinpoint areas of greatest need and inequity, we

strategically identify opportunities to form and participate in partnerships and contracting to impact the health of all Louisianians. We highlight several examples:

- **Serving as a Convener: UnitedHealthcare Catalyst™** is a clinical community-integration model that convenes and powers a formal collaboration of health care and community partners to identify and address health inequities. In 2020, our Louisiana-based team engaged Open Health Care Clinic (OHCC) and trusted CBO partners in Baton Rouge, including Bet-R Neighborhood Market, One-Stop Homeless Service Center, and Top Box Foods, and provided a **$250,000 investment** to establish a Catalyst. This includes a **defined contractual agreement** (Memorandum of Understanding) for collaboration and bi-weekly meetings to implement and evaluate interventions to address inequities. The Catalyst identified medical-behavioral-social integration as a key area of focus in the community and began initial interventions in spring 2021. Working with our Catalyst partners, we track process measures and are developing a formal evaluation plan to link interventions to health outcomes and will modify or scale interventions over a three-year period. Through an additional **$350,000** investment from UnitedHealthcare, we are launching a second **Catalyst in New Orleans by end of 2021** in partnership with the Housing Authority of New Orleans.
- **Collaborating with Ofice of Public Health (OPH):** We participate in collaborative efforts led by OPH such as the statewide efforts to **eliminate Hepatitis C**. In 2020, we launched our efforts to participate in the state's program to impact 40,000 people in Medicaid or in prison with Hepatitis C (just over 8,500 of our enrollees). Actively deploying our case managers and communicating with providers to make sure they understood the program and their role, as of Q2 2021, **42% of enrollees engaged in the program (2,708 are listed as cured/cleared, 371 have completed treatment and are awaiting results to be deemed cured and another 497 are currently in treatment)**.

  > "UnitedHealthcare was one of the first to embrace these changes and to **work with your providers** to ensure they feel comfortable offering the life-saving care they do every day now."
  >
  > *– Brandon Mizroch, MD/MBBS*
  > *Office of Public Health (OPH)*

- **Mobilizing Disaster Relief:** Throughout 2020, **we invested more than $1.2 million** in Louisiana communities and local infrastructure in response to COVID-19 and natural disasters impacting our state. Through the commitment and dedication of our Louisiana staff, many who had experienced their own personal losses, they were actively engaged and eager to assist our enrollees at the point of their needs. To support COVID-19 vaccine administration, we formed an amalgamation of strategic partnerships throughout the northern part of the state in collaboration with the Center for Emerging Viral Threats. Supporting local FQHC Mercy Medical Health Center in Hodge and the U.S. Department of Housing and Urban Development and the Salvation Army in Shreveport,. In the wake of Hurricane Laura in August 2020, **we acted immediately**, providing a **$500,000 donation** to the Community Foundation of Southwest Louisiana, and partnered with People's Health to distribute vital resources, including **6,500 safety/hygiene kits and more than 200 cases of water**. In anticipation of Hurricane Delta in the same region, our care management teams conducted outreach to **nearly 600 enrollees** to assist with evacuation or sheltering in place and locate resources.

2.6.5 Health Equity [12-page limit]

2.6.5.1 Describe the Proposer's management techniques, policies, procedures, and initiatives it has implemented to...

UnitedHealthcare's approach to addressing health inequities aligns with the Louisiana Department of Health's (LDH) definition of health equity – we work toward the day when "every person in a community has a fair and just opportunity to reach their full health potential." Addressing disparities and social determinants of health (SDOH) have long been our focus. We invested **more than $11 million in Louisiana communities since 2018** to directly address disparities in housing, food insecurity, disaster recovery, and infant and maternal mortality. Health inequities associated with race, ethnicity, language, disability, geography, gender, and sexual orientation, contributing to Louisiana's position as 50th in health outcomes (2020 America's Health Rankings), reveal there is much work to be done to achieve health equity. In our current contract, we strengthened our commitment, **centering equity as a guiding principle informing "how" we work, "what" work we do and "where" we do that work.** Advancing health equity is the foundation of our population health approach.

United in Louisiana
"I've always felt a commitment to more vulnerable or disenfranchised communities, as a result of my lived experience growing up in New Orleans. I'm exuberant because we're doing work we feel is meaningful and likely to be impactful. Our community-based relationships are often the tipping point to our success. **Together, we're doing things that make a difference.**"

- Julie Morial, M.D., MPH, FACP
Chief Medical Officer (CMO)

Techniques, Policies and Procedures to Promote Health Equity

We start with authentically listening to our enrollees and communities to identify needs and understand key local drivers of disparities, such as SDOH and health system infrastructure gaps. We leverage data from diverse sources, including claims, assessments (e.g., Health Needs Assessments [HNAs]), internal data tools (e.g., HealthView Analytics), and publicly available resources such as America's Health Rankings and LDH reports to identify and analyze disparities impacting our enrollees and communities. We collaborate with state and local government partners, community-based organizations (CBOs), providers, enrollees and other Louisiana MCOs to develop community-based interventions that address the complex roots of inequities.

We continuously enhance our infrastructure to sustain action and integrate equity principles within our business practices. In 2020, we established an internal **Diversity, Inclusion and Racial Equity (DIRE) Committee** that comprise our CEO, CMO, and local plan leaders from diverse backgrounds reflecting the communities we serve. The Committee includes over 20 employees whose goal is to provide a safe space for staff to talk about health equity topics, develop actionable tools and resources, and generate new ideas to address inequities related to structural racism, SDOH and system fragmentation. We are establishing a multidisciplinary **Health Equity Action Team (HEAT)** of leaders from across all functional departments (e.g., care management, quality, enrollee services, network) to be led by our new **health equity (HE)**

Our **DIRE Committee** identified a need for an expanded forum to engage, obtain input, and partner with CBOs, so we developed and launched an external **Health Equity & SDOH Collaborative Council (HESCC)** in June 2021 with community representation from each of the nine regions of the State.

administrator and accountable to maintain and improve techniques, policies, procedures and initiatives in our Health Equity Plan.

Initiatives Implemented to Promote Health Equity in Louisiana

Reduced Disparities in COVID-19 Testing and Vaccination
In 2020, we performed over ***4,800*** COVID-19 tests, 60% among people of color. In 2021, greater than 35% of the ***3,200*** COVID-19 vaccinations performed were among people identifying as Latino, Black or both.

An example of our health equity approach in practice is our **STOP COVID** community testing and vaccination. Recognizing the disproportionate impact of COVID-19 on communities of color in Louisiana, we developed and implemented an initiative focused on expanding testing (shifting to vaccination) capacity and providing wraparound services specifically in underserved Black and Latino communities. Our CMO, Dr. Julie Morial, and local clinical team used **HealthView Analytics** to map the CDC Area Deprivation Index (ADI) over existing COVID-19 testing locations to identify specific ZIP codes (Ninth Ward and Gert Town in New Orleans) with high concentrations of people of color and testing infrastructure gaps. We engaged local public health officials as well as faith-based organizations and community faith leaders to serve as the testing sites and trusted messengers in outreach efforts. In July 2020, we initiated **eight weeks of consistent community-based COVID-19 testing**, integrated with on-site connections to local health services, educational materials, safety kits, food boxes from Second Harvest Food Rescue, and resources from the Housing Authority of New Orleans. We launched **four vaccination sites**, determined by ADI data and stakeholder input, at New Orleans East DePaul Clinic, Thrive Community Center, Hispanic Apostolate, and Xavier University with on-site wraparound services and Spanish translation services. In addition, we partnered with CrescentCare on joint community outreach and education events in Spanish-speaking communities to address barriers to vaccination. Throughout our response, we provide examples of more initiatives using this data-informed, community-based approach.

Proposed Approach to Promoting Health Equity

Our 2022 Health Equity vision and goals align with our population health strategy to focus on prevention and addressing root causes of disparities. The table highlights our continued commitments. We look forward to working with LDH to submit our Health Equity Plan for approval.

Key Commitments to Continue to Promote Health Equity in Louisiana
Empower Enrollees through Personalized, Culturally Competent Supports
▪ Expand community and home-based support through **CHWs, peer supports and doulas** ▪ Require care team annual completion of specialized training in **health equity and implicit bias** ▪ Enhance proactive, regular screening for social needs and **closed loop referral** to needed resources
Embed Health Equity in Fabric of Our Business and Metrics of Success
▪ Hire or promote local **HE administrator** to lead a cross-functional **Health Equity Action Team (HEAT)** and develop and execute our **Health Equity Plan** ▪ Expand use of data analytics tools across all departments to design, implement and evaluate **coordinated initiatives to address enrollee disparities** ▪ Achieve **NCQA Distinction in Multicultural Health Care** by end of 2021
Evolve Care System to Increase Access and Drive Equitable Outcomes
▪ Invest in workforce development for a more ethnically and linguistically diverse provider network ▪ Equip and **offer provider education** and support with trainings to address **implicit bias**

Key Commitments to Continue to Promote Health Equity in Louisiana
▪ Deploy **value-based payment models** to incentivize improvements to reduce disparities in care
Engage Communities to Create Healthier, More Equitable Communities
▪ Leverage our Enrollee Advisory Committee, HESCC and community-integration models to engage stakeholders in shared decision-making and co-creation of solutions ▪ Invest in data-driven community capacity-building leveraging data from our SDOH Registry

2.6.5.2 Specifically describe strategies the Proposer uses or will use to recruit, retain, and promote at all levels, …

Strategies to Recruit, Retain and Promote Representative Personnel

Nearly 45% of our Medicaid enrollees in Louisiana are people of color**. Our health plan staff and key personnel leadership roles reflect these demographics,** [redacted] We will continue to recruit, retain and promote representative staff from the community with experience promoting health equity in Louisiana as described in the table.

UnitedHealth Group was recognized as 2021 Best Place for LGBTQ Equality, 2020 Best Place to Work for Disability Inclusion (DEI) and 2019 50 Best Large Companies for Women (Inc. Magazine).

Strategies to Recruit, Retain and Promote Representative Personnel and Leadership	
Recruit	Local and regional talent acquisition teams promote jobs to communities underrepresented in the workforce through partners such as INROADS, Prospanica, National Black MBA Association, LGBT Reaching Out and Historically Black Colleges and Universities in the State such as Dillard University. Our **Disability Inclusion Pilot Program** in Louisiana partners with Vocational Rehabilitation Agencies creating a pathway to hire candidates for positions on our clinical team.
Retain	To retain representative staff, we review and evaluate compensation practices to enable **pay equity**. Nationally, we found no difference in pay by gender or race for staff performing similar work at similar levels. Our retention plan enhances the experience for diverse employees through stay interviews, employee resource groups and mentorship. The DIRE Committee creates a forum for dialogue, training and development for staff at all levels of our plan.
Promote	Nationally, 36% of senior leadership are women and 11% are people of color. We need to do better, so our leadership established an enterprisewide goal to build a more reflective senior leadership team by 2030. UnitedHealth Group named a **chief diversity, equity and inclusion officer** with accountability to strengthen equity in our workforce. We use a Top Talent List and Talent Index to create pathways to senior positions and spotlight individuals for promotion. We also name managers from diverse backgrounds for leadership positions in succession planning.

2.6.5.3 Describe the Proposer's organizational practices related to ensuring the Proposer and its provider network …

Ensuring Culturally and Linguistically Appropriate Services

As part of our routine practice, **all staff** must complete **"Through Their Eyes"** cultural competency training to support national Culturally and Linguistically Appropriate Services (CLAS) standards and to meet the needs of enrollees, providers and business partners. Topics include medical interpreters, LGBTQ+ diversity and health literacy. We provide training from the Institute for Healthcare Improvement (IHI) Health Equity modules for our staff and providers. We collect data on enrollee language preferences and other needs to effectively communicate through our HNA and enrollee assessments, eligibility data (if available), referrals, provider encounters, enrollee services or at any other touch point. We offer **LanguageLine translation and assistance** services for our staff, providers or enrollees, including sign language or any of over 200 languages. Given that Spanish is

the second-most common language spoken among our enrollees and is a particular area of need among our moms, we are recruiting a **Spanish-speaking case manager** to specifically support pregnant enrollees. We use language and cultural preferences in our quality assurance efforts and to enhance staff training. The table highlights additional practices focused on provider CLAS.

Organizational Practices to Ensure a Culturally and Linguistically Appropriate Provider Network	
Diversifying Our Provider Network	We continue to build a diverse provider network to reflect our enrollees per the requirements of Model Contract 2.9.27.3. Our **Diverse Scholars Initiative** assists students in pursuing education in the health care field, providing $34,000 in scholarships to five Louisiana scholars since 2018. We are establishing a **four-year, $50,000 scholarship with LSU Medical School** for Black in-state students to address the deficiency of physicians of color. Leveraging local relationships from our CMO Dr. Julie Morial's position on the **LSU National Diversity Board**, we are exploring partnerships to encourage youth of color to pursue studies in STEM.
Facilitating Culturally Concordant Care	We enable provider-enrollee linguistic concordance by inserting language information in the *Provider Directory* of providers and their staff when available. We contract with organizations that specialize in supporting specific populations. For example, we partnered with **ALAS,** a non-profit serving immigrant youth to expand access to concordant telehealth supports for experiencing barriers to education and linguistically appropriate trauma-informed care.
Supporting Provider Cultural Relevance	Cultural relevance is an important topic within our provider orientation and refresher training (e.g., provider expositions and town halls). Educational materials include the *Care Provider Manual* and our *Practice Matters* newsletter, including articles such as **Support for Language Services and A Member's Right to Culturally Competent Care.** We offer training via our provider portal and professional, online continuing education related to caring for individuals with disabilities (live and recorded) through Healthcare Professional Education. We routinely monitor alignment to CLAS standards through our provider reporting.

2.6.5.4 Describe the Proposer's organizational capacity to develop, administer, and monitor completion of …

Develop, Administer and Monitor Health Equity Training Materials

Our local and national human resource and marketing teams have extensive experience developing and administering training that reflect the needs of specific populations. All staff, including management, providers, contractors and subcontractors, receive training on health equity and CLAS standards. We offer provider training using proven techniques such as onboarding and orientation webinars, site visits, town hall sessions, educational mailings and telephonic outreach. Some trainings offer CEUs focused on meeting CLAS standards and promoting health equity. We monitor and track completion rates of all trainings and provide reminders to encourage participation and completion, with an annual report to management to inform quality improvement efforts.

Example Training Topics on Health Equity Beyond CLAS Standards	
Internal Staff Training	Monthly education sessions on historic and structural racism, LGBTQ justice, disability justice and other topics through our DIRE Committee; UnitedHealth Group Advancing Health Equity online learnings series; **Anti-Defamation League anti-bias and empowerment** training have been taken by our health plan staff and leadership including Karl Lirette, CEO, and Dr. Julie Morial, CMO); Care Philosophy and **IHI Health Equity** modules (required for more than 80 clinical staff in Louisiana)
Provider Training	March of Dimes **implicit bias** training (Model Contract 2.6.1.2); **Adverse Childhood Experiences** (ACEs) training through a certified ACEs educator on our population health team; **SDOH Provider Toolkit** education conducted by our clinical consultants to increase provider awareness of available community resources

2.6.5.5 Describe the Proposer's demonstrated experience and capacity for engaging community members and …

Engaging Community Members and Providers to Address Disparities

In alignment with principles of Community-based Participatory Practice, we **engage stakeholders at every point of intervention design and implementation** through various channels (e.g., Enrollee Advisory Committee, Provider Advisory Committee) to collaboratively develop responsive solutions that address regional, cultural, socioeconomic and racial disparities among our enrollees.

Experience Addressing Regional and Socioeconomic Disparities

Despite significant need, there is not a single National Health Care for the Homeless Council (NHCHC)-accredited medical respite program in the State. This leaves many housing insecure individuals who have complex health concerns without a safe, stable place to recuperate post-inpatient stay with access to medical care, behavioral health and other supportive services. To address this gap, our housing liaison engaged key stakeholders in Orleans Parish, including Ozanam Inn, Health Care for the Homeless, Tulane, and LSU, to convene a collaborative of CBOs, the NHCHC, and multiple providers. UnitedHealthcare is committing **$100,000** and leading this collaborative effort to **create the first NHCHC-accredited Medical Respite facility in the State** by October 2021**.** The facility will include accessible accommodations (e.g., bed, on-site showers, laundry, secure storage, three meals a day), post-acute clinical care, care coordination and wraparound support services for those experiencing housing insecurity or homelessness.

> "Working with UnitedHealthcare during this COVID pandemic has been a very fulfilling partnership. We have collaborated on over 20 community vaccine events, specifically focused on increasing education and access for the Spanish speaking community. The social media and community outreach that they do helps link people to care and we are grateful to continue to work together to increase community knowledge of healthcare services and Latinx engagement in healthcare."
>
> *- Katie Conner, MPH, COVID-19 Vaccine Manager, CrescentCare*

Organizational Capacity for Engaging Community Members and Providers

All community and provider-facing staff are accountable partners engaging community members or providers in addressing disparities. For example, **our CHWs** live in and have deep connections to organizations across the nine regions of the State, and our **dedicated housing liaison** maintains strong relationships with permanent supportive housing programs and local housing agencies. **Our nine population health consultants** conduct ongoing outreach to providers in underserved communities to understand practice-level, regional, and systemic barriers to care and support provider capacity to close disparate gaps in care. Our four community outreach workers use tools such as Hotspotting and assessments to help identify disparities to build and maintain relationships with diverse organizations and providers across the State.

2.6.5.6 Does the Proposer currently utilize community health workers, peer support specialists, and doulas in any …

Experience Leveraging CHWs, Peer Support and Doulas

Our CHWs and peer support specialists meet enrollees where they are, build trusting relationships, and leverage lived experiences to address whole-person needs. We are committed to building upon

these efforts in alignment with 2.9.25.7 of the Model Contract, increasing use of credentialed peers and expanding access to culturally and racially concordant doulas to improve health outcomes.

Description of How CHWs, Peers and Doulas Are Utilized in Our Managed Care Program	
Community Health Workers (CHWs)	As a part of our Tiers 1-3 care management interdisciplinary teams, our CHWs assess at-risk individuals, identify social barriers, refer, and connect enrollees to appropriate community programs and resources. They conduct field-based outreach for hard-to-reach enrollees, including those with housing instability. CHW performance is measured and evaluated through outreach frequency and reach rate goals. We monitor gaps and recommend training, support, and partnership based upon program reporting (e.g., Healthy Start), including satisfaction and quality measures.
Peer Support Specialists (PSS)	We have used a peer support model in Louisiana since 2016 to assist enrollees with mental health, substance use, and comorbid conditions through living testimony, reinforcing resilience and self-management. PSS engage enrollees who are difficult to reach, bridge the gap between provider and enrollee, and assist in developing a support system. We are expanding our Louisiana PSS program to three peers overseen by a local **recovery and resiliency manager** who will expand collaboration with the provider community. All our PSS will be trained in Whole Health Action Management to promote behavioral health recovery with comorbid chronic condition management. PSS performance is measured and evaluated through utilization and other quality indicators. **Louisiana enrollees receiving peer support from 2018-2019 saw an 11.4% reduction in inpatient and ED spend**.
Doulas	We are committed to increasing access to doula services to fill a growing demand and improve maternal and birth outcomes, particularly among Black enrollees. In 2020, our Healthy First Steps (HFS) pregnancy case management program lead, Lynette Howard, MHA, BSN, RN, CCM, **completed doula training** to integrate doula services into our programming. We provided an **$85,000 grant to Birthmark Doula Collective** to fund their services and established processes for HFS case managers to refer enrollees to these services. Through our support, Birthmark doulas have completed **85 prenatal and postnatal visits, 34 deliveries, and 155 lactation appointments** in the first half of 2021. Building on this investment, we are developing a multi-year **Comprehensive Doula Services Pilot** with Birthmark Doula Collective to complement our integrated OB-GYN covered benefit, which will focus on Black enrollees with history of chronic disease. We will reimburse for doula services, measure enrollee engagement and prenatal/postpartum care rates, and evaluate impact on maternal and infant health outcomes.

Measuring and Evaluating Our Approach

We develop key process and outcome measures to track and evaluate effectiveness leveraging the **Institute for Healthcare Improvement-supported Plan-Do-Study-Act** (PDSA) framework. Our partnership with **NextHealth Technologies** enables our teams to conduct rapid program evaluation using machine-learning/AI analytics to identify whether CHW, peer, and doula interventions are effective relative to a matched control group and adapt interventions, as necessary. This includes the ability to segment enrollees (e.g., by race/ethnicity) to evaluate outcomes by subpopulation.

2.6.5.7 Describe how the Proposer will engage Medicaid consumers and trusted messengers, including …

Engaging Consumers and Trusted Messengers to Reduce Disparities

We engage Medicaid consumers and trusted messengers through multiple channels, including our Enrollee Advisory Council, **Health Equity & SDOH Collaborative Council, and our Wellness & Opportunity Centers** (opening in Baton Rouge in October 2021, with four more centers by 2023), to

understand barriers to quality care and gain insight into health disparities. We focus on individuals and organizations that come from and/or are trusted by our target population. The table highlights tactics to engage partners and evaluate our effectiveness to improve access and reduce disparities.

Partnership	Specific Actions	Timeline
Population Health Disparity Focus: Maternal and Infant Health and Chronic Conditions		
Healthy Start Home Visiting Pilot ***Objective:*** **Improve pregnancy outcomes for Black mothers with hypertension/ diabetes and their infants.**	Engage New Orleans Healthy Start to analyze data and input from listening sessions among pregnant Medicaid consumers, define target population, and design intervention	Q2 2020 - Q1 2021
	Implement pilot for 100 enrollees: HFS nurse case manager identifies and enrolls eligible enrollees; Healthy Start CHW conducts home visits throughout and after pregnancy, working collaboratively with the HFS case manager and the enrollee's care team to meet needs	4/2021 - Q1 2022
	Evaluate infant birth weight and gestational age at birth, NICU admission rates, prenatal and postpartum visit rate, blood pressure readings and medication adherence, provider engagement and enrollee satisfaction. Scale as appropriate throughout the State	Q1 2022 - Q2 2022
Population Health Disparity Focus: Mental/Behavioral Health Integration and SDOH		
UnitedHealthcare Catalyst – Baton Rouge ***Objective:*** **Increase clinical-community integration and collaboration to address community-defined disparity.**	Engage local FQHC and trusted CBO partners in bi-weekly meetings to establish a formal partnership agreement	12/2020 - Ongoing
	Jointly define community health disparities (medical-behavioral integration, transportation, food insecurity, health care access)	12/2020 - 2/2021
	Develop and implement initial interventions (placed behavioral health care manager at homeless shelter, gas and food vouchers, food boxes)	2/2021 - 12/2021
	Track process measures (e.g., food boxes) to improve implementation; develop evaluation plan linking interventions to health outcomes	7/2021 - 12/2021
	Modify/scale interventions based upon initial results and evaluate outcomes, leveraging NextHealth pre/post analytic capabilities	1/2022 - 12/2023

2.6.5.8 Describe the Proposer's data collection procedures related to enrollees' race, ethnicity, language, disability ...

Data Collection Procedures

How and which data are collected, analyzed, and reported significantly impacts our ability to understand inequities, set business goals, prioritize work and resources, and monitor and evaluate progress. **We currently have reliable race/ethnicity data for approximately 80% of our more than 500,000 Louisiana Medicaid enrollees.** We engage with enrollees during various touch points, such as welcome calls and assessments (e.g., HNA), to supplement race, ethnicity, language and disability (RELD) data collected and integrated into our systems from 834 enrollment files. Our quality team prepares an annual population assessment to track RELD data for enrollees. We will continue to collaborate with LDH and stakeholders to improve availability of RELD data.

Using Data to Provide Culturally and Linguistically Appropriate Services (CLAS)

Our local leadership and teams analyze RELD and geographic data to better understand our enrollees and inform decision-making. For example, recognizing Spanish (4.6.%) as the most common language spoken after English (94.1%) among enrollees in Jefferson Parish, we hired a Spanish-speaking community outreach lead to partner with culturally concordant organizations on Spanish-language community education and wellness activities. Our marketing and communications

teams regularly review local RELD data to develop linguistically and culturally appropriate materials in accessible formats. RELD and geographic data feed into our geo-mapping tools to identify actionable opportunities to improve access. For example, HealthView Analytics can filter population health measures or utilization data by race/ethnicity, urban/rural, and disability (e.g., SSI), to identify disparities and specific geographic areas for culturally and linguistically appropriate interventions.

Improving Incorporation of RELD and Geographic Data

Our national IT Workgroup assesses data completeness and reliability, identifies gaps and develops solutions. Our current focus is on improving race/ethnicity data completeness, later incorporating enhanced gender identify and language preference data. We are establishing a consolidated "source of truth" on race/ethnicity data to incorporate new sources such as enhanced data files from the Centers for Medicare and Medicaid Services. We are addressing non-standard race/ethnicity values or multiple values for each enrollee by setting up data systems and storage to capture and incorporate data into the appropriate usable format.

2.6.5.9 Describe the Proposer's demonstrated experience (if any) and proposed approach to utilizing RELD and …

Experience and Approach Using Data to Improve Health and Disparities

Our local enrollee and provider-facing teams have experience employing a data-driven, community-based approach to improve health outcomes and address disparities. Additionally, we used rural/urban data to assess network adequacy needs and identify geographic areas lacking in provider or service access based upon utilization and outcome trends.

We are strengthening our approach by incorporating use of RELD and geographic data across our health plan to develop coordinated, multi-level (enrollee, provider, community) initiatives to address disparities. This includes developing a disparity index methodology in HealthView Analytics to identify/monitor specific ZIP codes within each region with consistently low performance across multiple measures and focusing initiatives on region-specific inequities. We are incorporating RELD data into our value-based payment models to incentivize measurable enrollee improvement.

Using RELD Data in VBP
Our Shared Savings Community Connect program will include quality measures focused on racial disparities in the provider group's panel, directly tying their ability to earn additional shared savings to achieve improvements in disparities in health outcomes.

2.6.5.10 Specifically, how does, or will the Proposer, stratify, analyze, and act on data regarding inequities in care ...
2.6.5.10.1 Pregnancy: Percentage of Low Birthweight Births
2.6.5.10.2 Contraceptive Care – Postpartum Women Ages 21–44
2.6.5.10.3 Child: Well-Child Visits in the First 15 Months
2.6.5.10.4 Childhood Immunizations (Combo 3)
2.6.5.10.5 Preventive Dental Services
2.6.5.10.6 Immunizations for Adolescents (Combo 2)
2.6.5.10.7 Adult: Colorectal Cancer Screening
2.6.5.10.8 HIV Viral Load Suppression
2.6.5.10.9 Cervical Cancer Screening

Approach to Stratify, Analyze and Act on Data

We are incorporating these measures into our data analytics tools to stratify and analyze by age, gender, race/ethnicity, language, disability and geography. Through our HEAT and implementation

of our Health Equity Plan, **we will assess stratified measures at least quarterly to identify disparities**, new or enhanced initiatives, and track progress in mitigating disparities.

Measure	Our Experience Stratifying, Analyzing and/or Acting on Data
Pregnancy: Percentage of Low Birthweight Births	We stratified our data by race/ethnicity and found LBW rate to be 1.75 times higher among Black enrollees compared to white enrollees in 2018. We acted on these insights as described in Sections 2.6.5.11 and 2.6.5.13. Early results include a 13% improvement in timeliness of prenatal care among Black enrollees. Additionally, our Maternity Episodes of Care, described in 2.6.5.13 is showing promising results with a 9% reduction in c-section rates for predominately Black enrollees.
Contraceptive Care– Postpartum Women Ages 21–44	Using the postpartum care (PPC) measure as a proxy to assess disparities related to inter-conception care, we targeted enrollee outreach and community partnership in Orleans Parish, resulting in PPC improvements for all racial groups, including a 25% improvement among Black enrollees from 2018 to 2019, narrowing the disparity.
Child: Well-Child Visits in the First 15 Months	We analyzed the W15 measure stratified by race, ethnicity, English as primary language, and region. We used the Index of Disparity to identify statistically significant disparities in Region 8 and are targeting gap closure outreach activities.
Child & Adolescent Immunizations	We analyze child and adolescent immunization rates by race/ethnicity, gender, age, parish, and aid category (e.g., SSI) to identify subpopulations for enhanced outreach, as described in Section 2.6.5.14.
Preventive Dental Services	With LDH approval, we will work with the State's dental MCOs to stratify data for our shared enrollees by age, race/ethnicity, and geography to develop coordinated provider and community outreach and education initiatives to address disparities.
HIV Viral Load Suppression	Prevalence data stratified by race/ethnicity reveals that our Black enrollees are disproportionately affected by HIV/AIDS, accounting for more 58% of those diagnosed. Our adherence treatment rate for enrollees with HIV resulted in the highest compliance among MCOs at 82.59% (April 2021 LDH quality dashboard). As part of the Louisiana HIV Planning Group, we are working to stratify this measure by race/ethnicity, share insights, and act through community collaboration.
Adult: Colorectal Cancer Screening and Cervical Cancer Screening	Through the Taking Aim at Cancer Committee, we are using HealthView Analytics to identify 45- to 49-year-olds eligible for covered COL screenings residing in geographic areas with high ADI and SDOH indicators and acting on these data through targeted distribution of at-home screening kits with linguistically appropriate telephonic follow up.

2.6.5.11 Describe how the Proposer will leverage data analysis and community input to address inequities in …

Leveraging Data Analysis and Community Input to Advance Birth Equity

By engaging our community through listening sessions and symposiums, we learn about their needs and build our strategy to meet these needs. According to March of Dimes, preterm birth among Black women in Louisiana is 55% higher than among all other women. We saw this disparity reflected in our data, with Black enrollees delivering preterm at nearly 1.5 times the rate of white enrollees in 2018. In 2019, we partnered with the **Urban**

"It was an honor to be invited to the UnitedHealthcare MIH Symposium in 2019. It was motivating and enlightening to be in the midst of city, state, national and community leaders all responding to the crisis, and recent news of maternal and infant mortality rates affecting our community. **UnitedHealthcare is truly bridging the gap in maternal child health**."

– Mary E. Schultheis, President & CEO, Crescent City Family Services, Inc.

League of Louisiana to conduct four listening sessions across the State (New Orleans, Baton Rouge, Shreveport, and Alexandria) to better understand barriers directly from mothers in our communities. Of the participants, 88% were Black, 60% lived at or below the Federal Poverty Line, and 12% reported issues with substance use. We heard lived experiences such as difficulty accessing services due to transportation, connecting with their prenatal care provider, or feeling ignored in the ED when presenting with high blood pressure or pain.

We further invested $50,000 to hold a **Maternal and Infant Health (MIH) Symposium** in partnership with the **New Orleans Health Department and New Orleans East Hospital** convening providers, social service agencies, academic experts, policymakers, and others in collaborative learning and action planning. An additional $275,000 investment supported priorities and efforts identified by community input from the symposium, such as use of CHWs/home visiting, described throughout.

2.6.5.12 Describe how the Proposer will use feedback from enrollees and their family members to identify and …

Using Feedback to Identify and Execute Program Improvements

We gather feedback from enrollees and their families via multiple connection points and channels. We use stakeholder feedback to execute program improvements.

Examples of Experience in Louisiana

Programs	Enrollee Feedback	Implemented Program Improvements
Community Engagement	Expanded access/ awareness of resources	Enrollee Advisory Council and our new Health Equity & SDOH Collaborative Council for information-sharing and partnerships
Home Visiting	Face-to-face engagement during and after pregnancy	Healthy Start CHW Home Visiting Pilot for pregnant enrollees with hypertension and/or diabetes
CBO Collaboratives	Enhanced cross-system collaboration	UnitedHealthcare Catalyst™ in Baton Rouge and New Orleans by end of 2021
Doula Engagement	Social support and advocacy	Provided an $85,000 grant to Birthmark Doula Collective, which can lead to multi-year pilot
CHW Engagement	Social support and advocacy	$2.5 million to DePaul FQHC, $1 million which was focused toward CHW workforce development
Provider Training	Provider awareness of community resources	SDOH Provider Toolkit in targeted outreach and education activities

2.6.5.13 Specifically, which outcome measures does the Proposer propose to focus on to improve pregnancy and …

Improving Pregnancy and Birth Outcomes for Black Populations

Given disparities in our state, our outcome measures to improve birth outcomes for Black enrollees include percentage of low birth weight (<2,500g) births, preterm (<37 weeks) birth rate, and severe maternal morbidity. Our approach to improve outcomes includes actions to **empower** birthing people by uplifting Black voices, **evolve** the care system by dismantling systems of bias, and **engage** communities where our Black enrollees live through partnerships and capacity building, summarized in the table.

From 2018 to 2019, we saw improvement in PPC among **all** enrollees, including a **13% improvement** in timeliness of prenatal care and **19% improvement** in postpartum care among Black enrollees. This translated to a decrease in the disparity between Black and white enrollees.

Approach	Specific Activities to Promote Birth Equity *(Timeline)*
Empower Birthing People	▪ Deploy Healthy First Steps (HFS) Case Management for high-risk moms and mom-infant dyads in the Neonatal Intensive Care Unit (Ongoing) ▪ Initiate Wellhop Group Prenatal Care Pilot Program (Dec 2020 – June 2022) ▪ Expand access through Healthy Start Home Visiting Pilot (April 2021 – Q1 2022) ▪ Launch Birthmark Doula Collective Doula Services Pilot (timeline to be determined)
Evolve Care	▪ Implement Implicit Bias training among OB practices (June 2021 – Ongoing) ▪ Use value-based payments to drive equitable outcomes (Jan 2018 – Ongoing) ▪ Pilot Babyscripts remote patient monitoring at LCMC and Tulane (Jan 2022 – Jan 2024)
Engage Communities	▪ Convene listening sessions and Maternal and Infant Health Symposium (Q1 2019) ▪ Collaborate with CBOs such as Family Road of Greater Baton Rouge to connect enrollees to wraparound services to meet their needs (Ongoing) ▪ Launch and evaluate Mom's Meals home-delivered meals for high-risk moms experiencing food insecurity (Jan 2018 – current)

Empower Birthing People: We link enrollees to culturally appropriate providers and resources to support healthy pregnancies, deliveries, early childhood and family planning. Our eight regionally assigned and Louisiana-based HFS case managers engage high-risk pregnant enrollees, including Black enrollees, to participate in prenatal and postpartum care. We are developing a **multi-year pilot with Birthmark Doula Collective** for enrollees to engage in doula services to complement the prenatal/postpartum care they receive from our in-network physicians. In the spring of 2021, we launched a **Healthy Start Home Visiting Pilot** in partnership with the New Orleans Health Department to provide enhanced CHW support to 100 pregnant enrollees with hypertension and/or diabetes — which disproportionately impact Black enrollees. Healthy Start CHWs conduct in-home, telephonic, and virtual visits to identify and address needs and serve as an advocate throughout pregnancy and 18 months postpartum.

Evolve Care: In our listening sessions, moms relayed experiences of not being "seen" by their providers, feeling rushed during appointments, and limited resources for their non-medical needs. We developed trainings for our provider network and internal staff. We partnered with the CDC, Morehouse School of Medicine, and the March of Dimes on an **Addressing Maternal Mortality** training. We offered March of Dimes implicit bias training to 19 rural and/or independent OB practices with less access to this type of training. Additionally, we launched our Maternity Episode of Care payment model at Green Clinic in 2019, focused on metrics such as SMM and preterm birth rates, which disproportionately affect Black birthing people, and c-section rates. **Early results indicate a 9% reduction** in c-section births. Since high blood pressure disproportionately impacts Black enrollees, increasing risk for poor birth outcomes, we supported **LCMC and Tulane** in adopting the Babyscripts digital educational app and remote patient monitoring modules for hypertension and diabetes.

United in Louisiana

"I've been working in maternal and child health care for nearly 16 years. In a hospital, we see the moms come in with certain conditions, but we don't really have an opportunity to get to know them, what their home life is like or if they have family supports. When I can impact them on a personal level, where I know it will lead to something long term — really getting to know what the moms want — that's the most fulfilling thing for me. **I feel like this is what my life's work is supposed to be.**"

- *Lynette Howard, RN, HFS Manager*

Engage Communities: In 2020, we provided **$275,000 to seven Louisiana organizations** to expand services and supports for Black and other birthing people, including **$10,000 to National**

Birth Equity Collaborative to support birth equity training. In Baton Rouge with the highest volume of deliveries, 40% among Black enrollees, we provided **$50,000 to the Family Road Healthy Start** program for integrated wraparound services to 50 expecting mothers and provided **$15,000** to the **LA Center for Health Equity in Baton Rouge** to support an office of women's health. We provided a **$50,000 grant to Common Ground in Shreveport** to prevent teen pregnancy through expanded education (taught by medical director Dr. Glenda Johnson) and empowerment programs, with a focus on Black teenage girls and other youth of color. In our HFS staff maintains strong working relationships with organizations serving Black enrollees for bidirectional referrals and coordination. We connect enrollees to **Mom's Meals** during and after pregnancy to address food insecurity.

2.6.5.14 Describe the Proposer's relevant experience and proposed approach to engage parents and adolescents in …
2.6.5.14.1 Well-child visits and vaccination rates for children and adolescents.
2.6.5.14.2 Preventive dental services for children and adolescents.

Experience and Approach Engaging Louisiana Parents and Adolescents

Our local team includes our **dedicated EPSDT coordinator,** Heather Negrotto, pediatric nurse practitioner, and Karen Grevemberg, MBA, BSN, RN, population health manager with 20 years of experience in the State EPSDT. Our approach uses data to inform action, engages stakeholders to understand barriers and design/implement interventions, and evaluate and evolve strategies.

Addressing Disparities in Well-child Visits and Vaccination

We engage enrollees and their families by mail, text, IVR reminders, and case manager interaction for annual well-child visits and to address SDOH barriers to care. In 2021, well-child visits for enrollees ages 3 to 21 were the lowest in East Baton Rouge, Caddo, Jefferson and Lafayette Parishes. In April 2021, we added a one-time-per-year incentive of a $50 Walmart gift card for enrollees in these parishes, and a $20 gift card for all enrollees in this age group statewide. We ran provider gap reports and initiated targeted provider outreach and education on SDOH resources and incentives to encourage providers to engage families in adolescent well-care visits, well-child visits, and immunizations for adolescents.

Addressing Disparities in Pediatric Preventive Dental Services

We promote oral health in our EPSDT program. We have collaborated with MCNA's DentaLink program since 2018. Through the program, our top five high-volume medical PCP practices, such as Our Lady of the Lake, receive "prescription pads" to minimize the time a PCP needs to effectively recommend oral health care to enrollees, including identifying high-quality dental practices closest to the PCP in English, Spanish and Vietnamese. We will work with dental benefit managers (MCNA and DentaQuest) to establish processes for coordinated enrollee, family and provider engagement to increase pediatric preventive visit rates in the State as part of a comprehensive pediatric prevention strategy. Our proposed approach includes developing **joint disparity reduction initiatives** with the dental benefit managers to identify and address disparities in pediatric preventive dental visits. For example, pending LDH approval, we are exploring a partnership with MCNA to securely analyze matched data on preventive dental visits stratified by age, rural/urban and race/ethnicity to identify subpopulations experiencing disparities. Our initial focus is on Black and Hispanic children ages 1 to 9 without preventive dental visits in parishes with non-fluoridated water, magnifying disparities in oral health outcomes. We will identify pediatric medical practices for joint outreach, with plans to expand this model with DentaQuest based upon initial lessons learned.

2.6.6 Care Management [15-page limit]

The Proposer should describe its anticipated approach to meeting the care management requirements of this …

2.6.6.1 The Proposer's process for ensuring that there is success in completing enrollee health needs assessment …

Approach to Meeting Care Management Requirements

Over the past year, UnitedHealthcare has been continuously improving its care management model to fit the needs and expectations of the enrollees we serve. Our enhanced care model incorporates innovative programs, solutions, and technologies aligned with Louisiana's requirements and goals and national standards. We are implementing UnitedHealthcare's targeted care management solution, **Integrated Care Pods,** for our highest-risk enrollees. We made extensive investments to address Social Determinants of Health (SDOH) and behavioral health needs, and enhanced outreach strategies to connect with enrollees based upon their preferred methods. Using lessons learned from the COVID-19 pandemic, we are expanding virtual engagement tools to facilitate interdisciplinary, person-centered care.

Care Management Outcomes
Since May 2018, enrollees engaged in case management experienced the following:

- A 19% decrease in TCOC
- A 41% decrease in inpatient costs
- A 32% decrease in inpatient admits
- A 27% decrease in ED visits
- A 107% increase in outpatient MAT
- A 23% increase in MAT scripts

Since 2019, our care management model has evolved as demonstrated in the following examples:

- Developed and launched a medical respite program that wraps services around our most vulnerable homeless enrollees, providing a safe place to recover resulting in improved long-term outcomes
- Added two peer support specialists (with one more in 2021) offering their lived experience to support our enrollees with physical and behavioral health needs
- Invested in innovative, tech-enabled solutions, including a remote patient monitoring program for diabetes, and Babyscripts for pregnant enrollees receiving care from LCMC and Tulane (due to the number of high-risk enrollees they serve) to screen for hypertension and diabetes

Our redesigned care management model enables the most impactful experience for our enrollees by using an enhanced ID stratification process. A flexible algorithm aligns with LDH care management tiering requirements:

- **Intensive/High Risk (Tier 3) –** Enrollees with the greatest need receive clinician-led, interdisciplinary care management interventions tailored to address their primary risk factors. We identify high risk maternity and NICU enrollees, individuals with significant behavioral health needs, and our individuals with the highest physical health risk and impactful SDOH to align them with personalized care management programs.
- **Rising/Emerging Risk (Tier 2) –** For enrollees identified with rising risk, we offer clinician-led, interdisciplinary care management interventions along with targeted programs through national and local partnerships, designed to address specific conditions.
- **Low Risk (Tier 1) –** Making sure enrollees are connected to the appropriate primary care, specialists, behavioral health and substance use providers, and addressing SDOH barriers are

our top priorities. We connect enrollees with providers, educate and coordinate services to close gaps in care, and address HEDIS measures.

Risk stratification aligns with an individual's unique needs through local teams of care managers (CMs)[1] and a broader interdisciplinary care team (ICT). The ICT comprises medical and behavioral health experts, providers, pharmacist, housing liaison, case managers, community health workers (CHWs) and peer support specialists. The ICT supports customized care plans centered around the individual's needs whether medical, behavioral or SDOH, and care coordination is provided for all covered services and benefits.

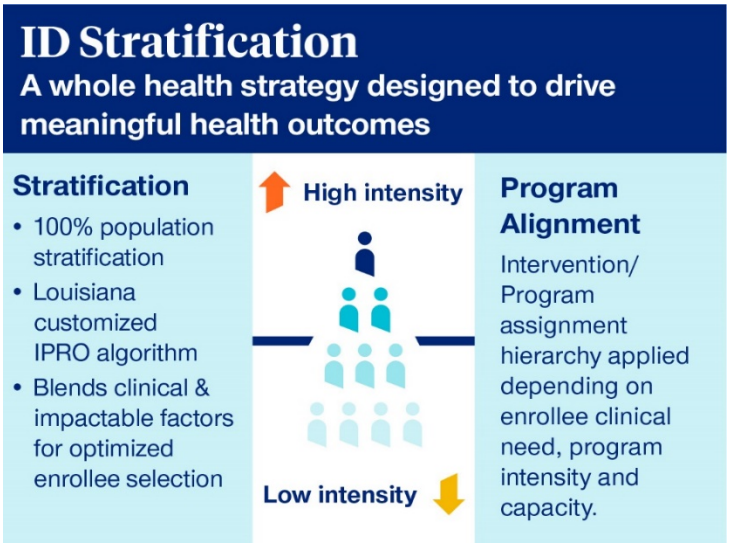

Figure 12. UnitedHealthcare's Identification/Stratification Model

Ensuring Success in Completing Health Needs Assessment

We conduct outreach through a variety of methods, including telephonic, print, web-based and in-person versions of the Health Needs Assessment (HNA) to meet our enrollees' diverse preferences. The welcome call is often our first live contact with an enrollee and helps us to understand them in a personal way. Within 30 days of enrollment, our Hospitality, Assessment and Reminder Center (HARC) team makes at least three attempts to complete the welcome call and HNA, calling on different days and at different times each day of the week to maximize success. It is critical to identify enrollees who may benefit from care management and connect them to resources as soon as possible. The enrollee can be reassessed if a change occurs, or at least annually for those in care management. The HNA provides actionable data on SDOH needs and drives one-on-one interventions and programming. We will use our experience with our current HNA with the rollout of a statewide standard HNA.

We perform exhaustive outreach efforts to connect with enrollees and complete the HNA, including:

- Incentivize enrollees with a $10 gift card for completing their HNA
- Attempt a total of three welcome calls by the HARC team
- Use every enrollee interaction to complete the HNA, including inbound calls to Enrollee Services and through our UnitedHealth Group/People's Health branded Wellness Centers located throughout the State
- Feet on the street to locate difficult to reach populations through our housing liaison and team, visits made by our case management team members, peer support specialists and our local PATH programs, and working with partners such as Eleanor Health, federally qualified health centers (FQHCs) and community-based organizations (CBOs) as appropriate
- Conduct up to six additional telephonic outreaches from a case manager for enrollees identified who could benefit from case management

[1] We use the terms care manager/management for health plan staff/services and case for provider-based staff.

- Continuously monitor and improve our process through call audits and coaching, monthly call reporting, an assessment dashboard and internal performance metrics

In 2022, we are adding further channels to complete the HNA to meet enrollees where they are:

- Conduct additional Interactive Voice Response (IVR) call after the initial welcome call to complete the HNA telephonically
- Send an email, via an enrollee provided address, encouraging them to complete the web based or telephonic HNA
- Send SMS message, to those who have opted-in to messaging, encouraging HNA completion
- Provide a web-based HNA via the Enrollee Portal connected to our care management platform

2.6.6.2 What tools the Proposer will use and how the Proposer will utilize those tools to identify individuals who …

Tools to Identify Individuals to Benefit from Care Management

We use a variety of tools and methods to help identify and stratify enrollees and connect them to the appropriate tier of case management. These tools and reassessments consider change in condition, need and health status. Our primary identification tools include:

- **Predictive Modeling (Impact Pro):** As part of our Health Risk Stratification Level Framework, we use a predictive algorithm, Impact Pro, which analyzes demographics, medical, behavioral, pharmacy claims and SDOH indicators, in addition to more than 300 clinical indicators. It identifies enrollees with gaps in care, high utilization, risk markers and condition-specific triggering events. This model been proven to identify 96% of members with an 80% or higher likelihood of having an acute inpatient encounter. **Impact Pro relies on a series of Impactable Care Management (ICM) indicators developed from clinical guidelines and national experience.** Case management teams are notified of newly eligible enrollees, who are placed in tiers based upon parameters of the risk stratification for outreach and engagement.
- **Hotspotting:** The strategic use of data to reallocate resources to a small subset of high need, high-cost enrollees. **Our Hotspotting tool allows a case manager or team member, such as a quality or population health analyst, to segment the population using over 50 filters** (e.g., risk factors, geography, demographic data including ethnicity, diagnosis, type of utilization, cost of care, SDOH needs, and mental health or substance use). Hotspotting provides population summaries and a detailed enrollee-level list to help guide any clinical outreach or intervention. The data can be applied to quickly target interventions for specific subpopulations **and is ideal for informing our population health strategy and mitigating health disparities**.
- **Special Health Care Needs Reporting – Historical Claims Data:** We use monthly reporting designed to capture data for those meeting the definition of Enrollees with Special Health Care needs and are referred for case management. Reporting is based upon ICD-10 codes in historical claims data and is cross referenced to Impact Pro data to make sure no qualified enrollee misses an opportunity to participate in case management.
- **Health Needs Assessments:** Evaluate each enrollee's health and wellness status and identify critical information, such as social, behavioral, medical, and functional conditions and needs; PCP and provider relationships; existing treatment plans; current services and utilization; and

barriers to accessing care. We refer enrollees with high-risk scores and needs to care management for assessment and enrollment. We connect pregnant enrollees to our **Healthy First Steps (HFS)** maternal and infant care management program described below.

- **Referrals:** We accept referrals from enrollees, families, providers of all types, state agencies, (e.g., Office of Behavioral Health, Department of Children and Family Service, or Office of Citizens with Developmental Disabilities), community organizations and partners, and UnitedHealthcare departments including enrollee services, utilization management, grievances and appeals, and NurseLine. We receive referrals through prior authorizations (e.g., PDN, PDHC, and PCS) and staff interactions (e.g., ED Navigator, housing liaison). In 2020, we established a Care Management Referral email address to receive referrals from any source for evaluation by our team. Our maternity value-based program (VBP) includes a Notification of Pregnancy (NOP) incentive for providers who identify enrollees early in their pregnancy.

2.6.6.3 How the Proposer will engage enrollees who may potentially benefit from case management in the …
2.6.6.3.1 Children and youth with special health care needs including behavioral health needs;
2.6.6.3.2 Pregnant and postpartum enrollees with substance use disorder and their newborns;
2.6.6.3.3 Children from immigrant families who may have unique cultural and linguistic needs;
2.6.6.3.4 Pregnant enrollees prior to delivery, to ensure that they will establish care with a pediatrician;
2.6.6.3.5 Enrollees at risk for rapid repeat birth, defined as pregnancy occurring within eighteen (18) months of a …
2.6.6.3.6 Adolescents transitioning to adulthood;
2.6.6.3.7 Children with type 1 diabetes mellitus;
2.6.6.3.8 Enrollees with adverse childhood experience;
2.6.6.3.9 Enrollees with food insecurity; and
2.6.6.3.10 Enrollees without reliable telephone access.

Engaging Enrollees in Case Management

Our identification and stratification tools analyze the entire membership each month. If an enrollee may benefit from case management, locally based care teams perform outreach and engagement to enroll them in programs tailored to their needs. The identification/stratification algorithm flags each enrollee's clinical and social risk areas to identify "impactable" opportunities (e.g., SDOH needs) and matches enrollees to the programming that best suits their needs. We deploy subspecialty case management teams with expertise in engaging high-risk groups such as pediatric special needs and HFS.

My Life's Best Work...
"I love my job because I'm able to serve the members. I love the fact that UnitedHealthcare allows us to be able to help the members and I love the fact that they're able to provide us with the resources. UnitedHealthcare goes out of their way to make sure the members know they care... It's not just a job, it's our mission."

–Ava Montgomery,
Shreveport CHW

Our integrated ICT engages enrollees with the right services and supports to meet their individual needs, We use motivational interviewing, culturally appropriate standards, and staff that live in the communities they serve and offer flexibility in the type of engagement including face-to-face, telehealth or telephonic outreach. Our geographically co-located staff can easily modulate the type of interventions and frequency up or down based upon enrollee preference, progression of goal achievement, and changes in need. We will use our network of Wellness Centers in the New Orleans metro area, Baton Rouge, Westbank, and Houma as part of our engagement strategy. At these centers, enrollees can complete an HNA, meet with a case manager or other support resource, access telehealth services, web services, phones, and find resources to meet SDOH needs. We are implementing and optimizing two targeted case

management programs: **Integrated Care Pods** and **Healthy First Steps** to focus on specific groups of enrollees and employ engagement strategies and interventions to address their needs.

Integrated Care Pods

Our intensive Integrated Care Pod (or "Pods") help enrollees with the highest needs. Enrollees engaged with a Pod are in Tier 3 case management. Pods are field-based, interdisciplinary teams consisting of a licensed nurse, licensed behavioral health advocate (BHA), CHW as needed, and peer support specialists. Pods leverage the local ICT for clinical expertise as well as guidance in specific disciplines such as housing navigation, recovery and resiliency, and pharmacy. Enrollees' primary health care concern/diagnosis determines whether the nurse or the BHA is the lead case manager. **Within the first three months of implementing our Integrated Care Pods in Virginia, we saw a 35.5% decrease in inpatient admits and a 9.4% increase in primary care visits (per 1,000 enrollees per year) for engaged enrollees.**

Figure 13. **Integrated Care Pod.** This team uses the support of subject matter experts to deliver intensive team-based care.

Pods mobilize the provider and community ecosystem to establish a sustainable support system that wraps around the individual. Pods help enrollees engage and strengthen informal support including family, friends and cultural or spiritual communities. Case managers coordinate directly with primary care and community providers to create a comprehensive individual plan of care (IPOC) that integrates all clinical needs and a "My Wellness Plan" to proactively identify strategies and resources in the event of a crisis. Case managers use this proprietary tool with enrollees to create a strong crisis plan. It helps them to become more self-aware of signs and symptoms that may precede a crisis and outlines proactive steps a person can take to mitigate escalation. Elements unique to Pods include:

- **Intensive Engagement:** Clinicians manage caseloads approximately 25:1 to ensure capacity for biweekly engagement focused interventions.
- **Protocol-driven Interventions:** Priority conditions (e.g., diabetes, CHF, COPD, OUD/SUD, and SMI) are addressed through evidence-based pathways based upon readiness to change.
- **Provider and Community Coordination:** Pods identify formal and informal support systems and orchestrate their engagement to support a unified approach to achieving enrollee goals.

Healthy First Steps – Maternal and Infant Care Management Program

Healthy First Steps, our maternal and infant care management program, is designed to provide tailored education and support to empower pregnant women and connect them to perinatal care to improve maternal and infant health outcomes. In 2020, our Louisiana HFS program supported more than 10,000 deliveries. Our **HFS case management team** is staffed by RNs, LPNs and CHWs who are trained in obstetrical health needs and evidence-based practices such as trauma-informed care, adverse childhood experiences, motivational interviewing and harm reduction, and person-centered care to help us better engage pregnant enrollees. Additionally, our HFS team refers and collaborates with our BHAs as needed. High-risk pregnant women receive case management, with specific support for mom-baby dyads in the NICU. Herein, we describe broad supports offered for all

enrollees in our HFS program, and subsequently we describe specific considerations for groups of maternal and child enrollees (e.g., pregnant enrollees with SUD).

Pregnancy Care Management Interventions

Our HFS program offers extensive **Perinatal Education;** every identified pregnant woman receives a **welcome letter** with information about our HFS maternal and infant care management program, and **educational materials on what to expect from their pregnancy**. Our HARC team maternity specialists share information about our **24-Hour SUD Helpline, and 24-Hour NurseLine.** The HFS team facilitates connection to perinatal care through regular appointment reminders, addressing barriers to care and assisting in scheduling as needed. We provide **After-Delivery Kits** and direct enrollees to the HFS website to find information on breastfeeding, postpartum depression, newborn safety, and more. Additionally, all enrollees will have access to our mobile-friendly **HFS Rewards Program**, which encourages enrollees to make and keep doctors' appointments, including well-child visits with their pediatrician, through their child's first 15 months of life. The program provides **rewards for the mom-baby dyad** through the child's first 15 months of life, such as **gift cards** and **diaper bags.** The HFS team screens all postpartum enrollees for depression using the PHQ-9 assessment and helps pregnant enrollees **address unmet social and safety needs,** such as transportation or food insecurity, by connecting them to care and local resources (e.g., Crescent Family Services, WIC, SNAP or Second Harvest Food Bank). We provide **Mom's Meals** for our highest risk pregnant and postpartum enrollees.

Participating HFS Rewards Enrollees:

- Attend 14% more physician visits
- Have 5.7% lower rate of ED utilization than nonparticipants

Specific Considerations for Groups of Enrollees

Each of the specific groups of enrollees designated in the RFP receive outreach and engagement through our care management process and team. When these specialized needs are identified, our care management team engages with the enrollee and/or family/caregiver to make sure they receive the services and supports to meet their holistic needs.

Case Management Improves Outcomes for CYSHCN Enrollees

Since May 2018, CYSHCN enrollees experienced the following changes after engagement in case management:

- A 30% decrease in total cost of care
- A 68% decrease in inpatient admits
- A 31% decrease in ED visits
- A 13% increase in behavioral health professional expense

Children and youth with special health care needs (CYSHCN) including behavioral health: The UnitedHealthcare Pediatric Specialty Program Team comprehensively monitors and assesses pediatric special needs enrollees through our ongoing work as care managers and review of prior authorizations for Private Duty Nursing, Pediatric Day Health Care, EPSDT Personal Care Services. CMs identify the biopsychosocial needs of enrollees through specialized assessments. They educate and support parents or caregivers on options and opportunities to transition medically stable children into childcare programs or public schools that are developmentally appropriate to support the enrollee's needs. Through meetings with the Louisiana Department of Health, Early Steps, Office of Behavioral Health, and the Department of Education, we foster relationships with advocates for childcare and development centers such as the Goldman School in Shreveport and Head Start centers (statewide). We will continue to identify partners that are prepared and equipped to safely support the transition needs of our pediatric special needs' enrollees.

Pregnant and postpartum enrollees with SUD and their newborns: Early identification and engagement are critical to connect to evidence-based treatments and broader medical, social, and behavioral supports. To identify pregnant individuals with SUD earlier, we **screen for SUD** through our pregnancy specific comprehensive assessment, including Substance Use Screener and TWEAK, which screens for alcoholism or heavy drinking, and use claims data, **pharmacy utilization reports** and pharmacy edits to alert our internal care teams and providers when a pregnant individual is filling an opioid prescription to provide counseling, connection to MAT, and further support**.** Our local HFS CMs receive **SUD training** to help pregnant enrollees with SUD navigate the complexities of pregnancy and treatment, providing case management through the postpartum period. Additionally, we provide enhanced telephonic and in-person outreach for hard-to-reach or hesitant to engage individuals, **and we offer a free, anonymous 24-hour SUD helpline** staffed by behavioral health clinicians. Our HFS CMs may refer a pregnant enrollee with SUD to programs such as **Guiding Recovery and Creating Empowerment (GRACE) at Woman's Hospital in Baton Rouge or Eleanor Health.** Eleanor Health is a comprehensive provider of SUD treatment and wraparound services that offers same-day and next-day access to in-person or virtual treatment. We are currently working with Eleanor Health to enable their on-the-ground Access Teams in Baton Rouge, Metairie, and Shreveport to proactively engage our highest needs enrollees. We are expanding access to evidence-based MAT treatment by contracting with providers such as **BrightHeart Health** who **offer tele-MAT services** and treat pregnant individuals with MAT and broader mental health and SUD supports.

GRACE Program at Woman's Hospital in Baton Rouge
In August 2018, we provided a $1.2 million grant to Woman's Hospital to implement the GRACE program. Staff support pregnant women with SUD through comprehensive case management services, one-on-one support by providers trained in obstetrics and addictive disorders, and referrals to evidence-based treatment such as MAT. **Of enrolled GRACE patients, 60% receive MAT treatment and 90% are connected to behavioral health counseling.**

Children from immigrant families with unique cultural and linguistic needs: Our HARC team has Spanish-speaking staff who assist enrollees in completing an HNA. In addition, our teams leverage translator language lines, with access to over 240 languages including tele-translation services for those who need American Sign Language (ASL) when in-person translators are not available. We are partnering with ALAS, a New Orleans-based 501c3 organization focused on youth who are experiencing legal barriers to their education due to immigration or criminal court proceedings, many of whom experienced severe trauma early in life. Our partnership connects enrollees with linguistically appropriate local and telehealth-enabled behavioral health providers and provides funding for ALAS for their programs.

Pregnant enrollees prior to delivery, to make sure they will establish care with a pediatrician: Our HFS program supports pregnant enrollees engaged in perinatal care for their infants through education (e.g., **After-Delivery Kit**) and personalized telephonic and in person outreach, addressing any barriers to care, such as **transportation,** through **non-emergency medical transportation (NEMT)**. If enrollees need one-on-one assistance finding a pediatrician, our CMs help enrollees locate pediatricians in their communities and encourage them to do so prior to delivery. Our HFS team provides **Appointment Reminders and Scheduling Support,** and all enrollees will have access to our mobile-friendly **HFS Rewards Program**. This interactive incentive program encourages well-child visits with their pediatrician, and the HFS website provides appointment reminders via text and/or email. Our Louisiana **Wellhop** pilot provides virtual pregnant peer group

prenatal support and education for pregnant enrollees of similar gestational ages through the postpartum period, to encourage engagement in care and provide information.

Enrollees at risk for rapid repeat birth: Birth spacing may reduce the risk for poor birth outcomes such as preterm birth and low birth weight making it critical to receive education and support regarding family planning prior to delivery or during the postpartum period. Our HFS CMs assist in scheduling postpartum visits, addressing other supports as needed and educating enrollees on topics such as long-acting reversible contraceptives and the importance of family spacing. Additionally, every pregnant enrollee receives an **After-Delivery Kit**, which encourages scheduling their postpartum visit and provides information on the importance of birth spacing. Additionally, we assess all women of child-bearing age to discuss family planning needs, such as contraception, by referring them to their PCP and providing resources through the **Bureau of Family Health Reproductive Health Program**.

Adolescents transitioning to adulthood: We identify and support youth and adolescents that are close to transitioning to adulthood to establish care with an adult PCP or specialist. Enrollees and their parents have access to the Enrollee Portal where resources such as the Transition to Adulthood Guide from the Center for Parent Information can be found. We utilize a Pediatric to Adulthood Transition assessment to tailor care plans to enrollees in this age group and the unique needs related to becoming an adult. For those living with special needs, chronic, or high-risk conditions, our care management interventions include education on how to live and manage a diagnosis into adulthood including transitioning care to adult providers and community supports.

Children with type 1 diabetes mellitus: With UnitedHealthcare supporting SDOH needs, access to clinicians and dieticians, medications, behavioral health support and education around their illness, most children with type I DM and their caregivers can manage their condition while remaining in traditional child-care, school settings, and extra-curricular activities. **Through our case management of children with diabetes, we have reduced inpatient stays by 47% and ED visits by 16%.**

Enrollees with adverse childhood experiences (ACEs): We provide special screenings including the PEARLS (Peds) and ACEs questionnaires in our Behavioral Health Toolkit for Medical Providers on our provider portal. Our Medical Directors facilitate education and support to help community providers identify ACEs in their engagements and to help enrollees receive the appropriate care and support they need following a disclosure or report. Our Medical Directors, care management teams and supporting staff receive ongoing specialized training on ACEs and Trauma-informed Care.

Enrollees with food insecurity: When food needs are identified at any touch point, our CMs identify either acute and/or long-term needs and provide referrals, including SNAP (Supplemental Nutrition Assistance Program), local food pantry sites and WIC for pregnant individuals and parents. All enrollee-facing staff utilize Aunt Bertha/Unite Us to identify the most current and appropriate resources based upon enrollee locale. Through our partnership with Mom's Meals, Louisiana enrollees discharged from an acute inpatient hospital stay, high-risk postpartum enrollees, and those discharging from a hospital stay with a COVID-19 diagnosis and need to quarantine are offered two-weeks of home delivered nutritiously prepared meals. Additionally, **we provided $250,000 to Second Harvest Food Bank** to purchase and deliver 1 million grocery boxes for children, seniors, and families in need.

Enrollees without reliable telephone access: We conduct "feet-on-the-street" outreach to locate individuals without telephone access or who are hard to reach. We will use our partnership with

Assurance Wireless to offer free smartphones to enrollees in need of reliable phone access provided by SafeLink, part of the Federal Lifeline program. It allows our CMs to outreach and engage enrollees, coordinate care and follow up on health improvement activities. We will leverage our Wellness Centers to assist enrollees with access to phone services, make appointments, and provide computers for local telehealth visits until they receive their smartphone.

2.6.6.4 How the Proposer will identify the appropriate tier of case management for an enrollee using objective …

Identifying the Appropriate Case Management Tier

Case management tiers align to the unique needs of each individual and consider the presence of acute and chronic diagnoses, health care utilization, care transitions and SDOH needs. Enrollees can transition between the levels of service depending on successful completion of goals identified on their individualized plan of care, management of chronic conditions, or impact of SDOH needs. UnitedHealthcare's case management model aligns to LDH's expectations and meets the diverse needs of our enrollees.

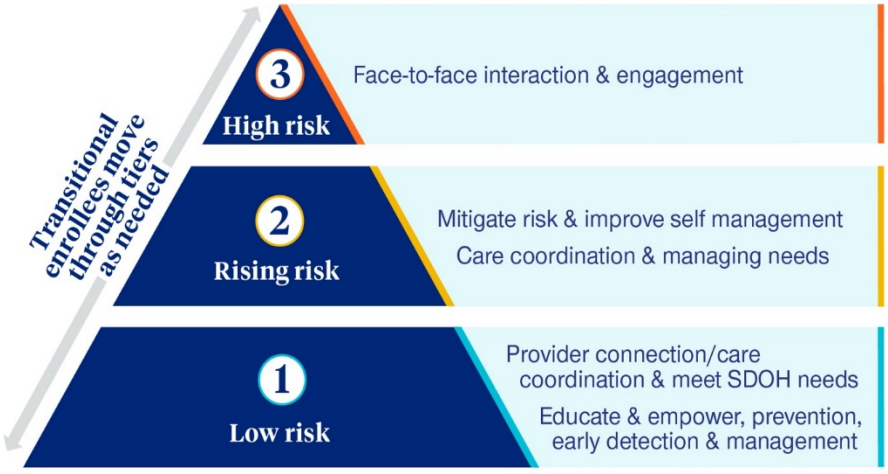

Figure 14. Health Pyramid. Our approach to enrollee outreach and engagement.

Our approach applies objective measures and criteria using clinical assessments and data mining from claims and health information exchanges to stratify enrollees into subpopulations. Clinical need and identified risk inform the appropriate tier. Data points feeding our stratification process include:

- **Screening and Assessments:** Clinical needs are identified through the initial HNA, comprehensive assessment for enrollees in care management, Maternity Initial Risk Assessment (MIRE) for pregnant individuals, SDOH screening and other assessment tools.
- **Impact Pro (IPRO):** Discussed further below, IPRO is the claims analytics engine that runs our monthly algorithm, stratifying enrollees into risk tiers aligned with LDH's care management tiers.
- **Care Team and Direct Referrals:** Our person-centered design allows enrollees to self-refer for any level of care management service. Additionally, our care teams can make recommendations to move enrollees to different levels of service based upon progress or worsening condition.

We orient each tier to the appropriate level of risk and complexity surrounding our enrollees and consider the pragmatic use of interventions and resources across tiers. Enrollees are engaged by a case manager based upon primary need or risk factors.

Tier	Lead	Enrollee Risk Factors such as:
Tier 3 Intensive/ High Risk	RN or BHA	▪ Individuals identified via IPRO (e.g., multiple chronic conditions, need for uninterrupted care, pattern of ED and hospital admissions) ▪ High-risk pregnancies, for example women with substance use, sickle cell, or severe physical or behavioral health conditions ▪ Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and/or presented to the ED for suicide attempt ▪ SUD/OUD and presented to ED for overdose treatment ▪ Experiencing homelessness per Section 330(h)(5)(A) of the Public Health Services Act
Tier 2 Rising Risk	RN or BHA	▪ Identified by IPRO Emerging Risk factors with a chronic condition but not engaging with the health care system at appropriate levels for their condition or no routine monitoring or testing ▪ Diagnosed with post-acute sequalae of COVID-19 (PASC or "Long Haul COVID") ▪ Pregnant enrollees with minor complications such as stable chronic conditions, mild depression or who have a history of miscarriage ▪ Experiencing housing insecurity or two or more SDOH needs that put them at risk ▪ DOJ My Choice "At Risk" population PASSR Population
Tier 1 Low Risk	RN, BHA and/or CHW as needed	▪ Healthy pregnant enrollees ▪ Seeking new providers (e.g., care settings that offer multiple services/specialties) ▪ Experiencing lower intensity SDOH needs (e.g., transportation barriers, need for smartphone)
Transitional Enrollees moving between institutional or community care settings	RN or BHA	▪ Children with special needs moving from pediatrician to adult PCP and/or specialist ▪ Back into their community after incarceration (Department of Corrections Program) ▪ To/from inpatient settings such as hospital or nursing facilities ▪ To/from PRTF, therapeutic group homes, Intermediate Care Facilities (ICF/DD) ▪ To/from residential substance use disorder treatment facilities ▪ To permanent supportive housing

Impact Pro "Impactable" Case Management

Our Impact Pro (IPRO) ICM indicators help to identify, stratify, and prioritize enrollees who are clinically at risk and have impactable opportunities that can be addressed and acted upon immediately to make a significant difference in their quality of care. These indicators provide a solid foundation to build a comprehensive case management strategy. Two categories of distinct rules characterize these ICM indicators:

- **Clinical Risk** indicators determine which enrollees are either high complexity/high risk or emerging risk
- **Impactable Factor** indicators expose areas where enrollees may not be following recommended guidelines, potentially receiving care that is wasteful or overly complicated, in need of additional services based upon presence of chronic conditions, or if an enrollee has other contributing circumstances that may warrant further attention

There are 44 indicators that support our predictive algorithm: 23 Clinical Risk and 21 Impactable Factor indicators. Each indicator is assigned a score ranging from 1 to 3, with 3 referring to the highest clinical risk as aligned with our case management tier structure. The scores are summarized by enrollee across the ICM indicators and used to assign an enrollee to Tier 1, 2 or 3 which determines the type of interventions and care management engagement an enrollee receives.

Types of Support for Each Tier

Our integrated interdisciplinary care model makes sure enrollees receive the right services and supports to meet their individual needs, with a focus on reducing health disparities and creating a culture of equity and equitable outcomes. Structural, socioeconomic and environmental factors underlie and affect individual and population-level engagement with the health care system and health outcomes. Our trained care teams focus on fostering authentic relationships with the individuals we serve, building trust, linking to, and supporting community programs, elevating enrollee and family voice and supporting them to meet their self-identified goals at each touch point.

Foundational Case Management Support and Intervention by Tier

Tier Level	Assessments/Services
Tier 1 – Low Risk Case Management	Comprehensive assessment (in-person); SDOH screening and closed loop referral support; initial individual plan of care (IPOC) within 90 days of enrollment; annual reassessments; IPOC updates as needed but at least annually; care transition and post-discharge support within seven days of transition; quarterly meetings with enrollees; and Wellness Center access for virtual care or to make progress toward goals
Tier 2 – Rising Risk Case Management	Comprehensive assessment (in-person); SDOH screening and closed loop referral support; initial IPOC within 30 days of enrollment; quarterly reassessments; IPOC updates as needed but at least quarterly; care transition and post-discharge support within seven days of transition; monthly meetings with enrollees; and Wellness Center access for virtual care or to make progress toward goals
Tier 3 – Intensive Case Management	Comprehensive assessment (in-person); SDOH screening and closed loop referral support; initial IPOC within 30 days of enrollment; quarterly reassessments; IPOC updates as needed but at least monthly; care transition and post-discharge support within seven days of transition; monthly meetings with enrollees; and Wellness Center access for virtual care or to make progress toward goals
Transitional Case Management	SDOH screening and closed loop referral support; initial IPOC prior to discharge; care transition and post-discharge support within seven days of transition; meetings with enrollees after discharge as needed; and Wellness Center access for virtual care or to make progress toward goals. PRTF, TGH, or ICF/IID post discharge services will be in place 30 calendar days prior to discharge

Interdisciplinary Care Team

Our dynamic ICT mitigates system fragmentation, activates the right level of support for the right goal, and makes sure all components of the enrollee's social-environmental ecosystem are operating in tandem. We facilitate ICT meetings to provide greater depth and understanding of an enrollee's engagement and adherence while promoting collaboration and integration. We host joint rounding and clinical case conferencing across programs, geographically orientated teams, and plan level subject matter experts to strategize effective interventions to address integrated care needs. Our **Integrated Care Pods** operate within the health plan's larger ICT framework. Pod staff serve as experts to engage enrollees with the highest medical complexity and risk factors that can be impacted positively by intervention.

Intensive Case Management for High-Risk Enrollees (Tier 3)

This level of case management is structured to support enrollees who are at the highest risk for or are experiencing hospitalizations, institutionalization, or frequent and ongoing adverse outcomes related to their current health status. The goal of this level of care management is to leverage the enrollees' strengths, natural supports, and community resources or services to reduce risk for emergency or acute care, improve or maintain functional level, independence and safety in current environment, and focusing on an enrollee's person-centered goals. Interventions include primarily face-to-face visits in the community, whether in an enrollee's home, at a provider's office, place of worship, community center or other enrollee preferred meeting location.

Enrollees in intensive case management are engaged through additional and more intensive interventions than what is offered in rising risk (Tier 2) and low risk (Tier 1) case management. Examples of some of the interventions we use include biweekly to monthly visits with the assigned care manager including face-to-face engagement; care transition support, medication reconciliation, disease education, HEDIS gap closure; engaging providers and CBOs or informal supports (family, faith-based, cultural/ethnic associations) to align with enrollees' clinical, service or treatment goals. Our CMs use our proprietary "My Wellness Plan" tool to help enrollees create a strong crisis plan for both physical and behavioral health potential crises.

High Touch Advocacy for Tier 3 Enrollees

Our case management team in Baton Rouge is focused on individuals with serious mental illness, moderate to severe substance use disorders, or co-occurring disorders with three or more ED admissions or higher level of care in the past six months. This team-based model uses a field-based peer support specialist and behavioral health advocate using person-centered planning tools to collaborate and actively engage the enrollee to fully participate in their recovery and provide crisis support tailored to their needs. In 2018-2019, our local peer support specialist assisted enrollees to **reduce medical and behavioral inpatient and emergency department utilization by 11.4%** and **outpatient services by 12%** for six months pre and post engagement in peer services.

Case Management for Rising Risk (Tier 2)

This level of case management is structured to support enrollees who are at risk for hospitalization and adverse outcomes related to their level of engagement with the health system. Interventions focus on mitigating movement up the continuum of health risk through self-management, engagement with providers and establishing sustainable community supports. The assigned CM plays a central role in connecting enrollees to appropriate providers, coordinating health services and benefits, supporting self-efficacy, and engaging community and provider support. Examples include medication reconciliation and education based upon condition and developing crisis plans in the event of a worsening medical, behavioral health or SDOH need. CMs use motivational interviewing to facilitate behavior change and promote progress toward enrollee priorities and goals.

Low Risk Case Management (Tier 1)

This level of care management is structured to support enrollees who need to connect to providers with low risk SDOH and care coordination needs. Enrollees in this tier may be supported by CHWs with an escalation pathway to a nurse and/or behavioral health advocate as appropriate. For enrollees identified for low-risk case management, we address and resolve barriers to accessing preventive and specialty services, leverage targeted education based upon condition, connect to

community and natural supports, and enhance self-management strategies, ultimately reducing risk of increasing health needs.

Proven Disease Management Interventions
In our CHIP programs nationally, our interventions resulted in lower ED utilization rates between Q1 2019 and Q1 2020.

- **ADHD:** 6% reduction
- **Asthma:** 8% reduction
- **Depression:** 8% reduction

Tier 1 interventions educate and empower enrollees to proactively participate in their health through emphasis on prevention, early detection, and management of health conditions. We augment an enrollee's relationship with their primary and specialty care providers through evidence-based condition management supports. Our multimodal approach relies on array of health promotion tools and resources to engage enrollees and provide support tailored to their circumstances. Our targeted programs include a suite of interventions that include an **annual individualized plan of care, educational mailers, self-management tools, specialized partnerships, rewards** and **medication management programs**. We provide tools and strategies for enrollees to **navigate the health care system** to manage their health effectively and proactively.

Transitional Case Management

Our transitional case management program evaluates social, behavioral, and physical health needs and coordinates support services to arrange for safe and appropriate care from one care setting to another such as enrollees who are moving between institutional or community care settings. The goal for enrollees experiencing a transition in care is to influence adherence to post-discharge plans, engage with providers for follow up and resolve barriers or confusion related to new or changed conditions to prevent readmission or continued use of emergent and acute services. Transitional case management can be provided across any risk tier, as depicted above in Figure 14.

We can identify enrollees experiencing transition through real-time admissions, discharges and transfer (ADT) alerts in our clinical management platform and Health Information Exchange, enrollee or family notification, ongoing enrollee touch points, provider identification or authorization request, utilization management daily census reporting, alerts from homecare providers, and notification from the NurseLine or behavioral health crisis hotline teams.

For individuals in case management who require discharge planning, we collaborate with the enrollee, the facility, and their chosen planning team to develop a transitional plan of care to make sure progress made during the inpatient stay continues after discharge. We use a Readmission Predictive Model on historical claims data, or for new enrollees, we use our Risk Screening Tool to understand an enrollee's readmission risk, to prioritize their need for transitional case management. The process includes medication reconciliation, patient education and self-management strategies, addressing any prior authorization needs and connection to resources for enrollees experiencing homelessness. We offer Care Angel, an AI-powered Virtual Nurse Assistant service that calls members transitioning from hospital to home to confirm post-discharge appointments are made and to check on discharge instructions or symptoms, escalating to a nurse as needed. Care Angel has engaged 165 enrollees in LA for post-discharge support**,** who receive calls for a 30-day duration.

Transitioning Between Tiers: Evaluation of Impact and Reassessment

During regular touch points, continual monitoring of the enrollee's health status, reassessments, and IPOC updates, our CM works with the enrollee and their ICT to look for indications the enrollee can move to a lower tier of case management or that a higher level is needed. Indications that an

enrollee may be ready to move to a lower level of care management include evidence that the drivers of utilization, such as homelessness, have been addressed; goals in their IPOC are achieved, adherence to treatment plans, and resources have been accessed (e.g., transportation). Enrollees who could benefit from tier escalation can be identified by changes to their living situation, recent acute events such as hospitalization or surgery, or emerging SDOH needs.

Developing Individual Plans of Care

Our care planning process, founded on principles of recovery and self-determination, focuses on strengths, and empowers enrollees to lead the planning process and actively participate in all aspects of care planning. The CM works to develop an integrated POC that includes services and supports to meet needs and preferences to achieve their goals and outcomes. An individual POC is developed to coordinate and integrate care for enrollees who may only receive behavioral health benefits.

We engage the enrollee's providers, at the enrollee's discretion, to participate in care plan development. PCPs have access to our integrated, secure care management platform, offering real-time information to monitor and support progress toward achieving goals, engaging in health, and sustaining long-term behavioral change resulting in improved health outcomes. We engage other supports such as community organizations, spiritual leaders and others as preferred by enrollees.

The POC highlights the enrollee's attributes as a foundation to achieve positive outcomes based upon their unique situation and needs. It is not static, but continually updated with the enrollee based upon changing needs and progress. We collaborate with the enrollee to update their plan of care at each interaction. We also update the POC upon enrollee/caregiver request or if the enrollee shows signs of deteriorating health, experiences a change in circumstances (e.g., loss of a caregiver) or has an acute event, such as a hospitalization.

2.6.6.5 How the Proposer will coordinate with providers and State staff that may provide case management …

Coordinating with Providers and State Staff

We first identify providers and/or state staff providing case management services for our enrollees, then establish communication processes, and actively coordinate assessments, care planning, and discharge planning and include these partners in ICT meetings. For example, we collaborate with support coordination agencies engaged with Chisholm Class Members or enrollees in waiver programs, child welfare staff, community mental health centers, Magellan (who manages the Coordinated System of Care), Department of Corrections staff, Adult and Elderly Protective Services, and Office for Citizens with Developmental Disabilities. We are willing and eager to collaborate and coordinate services with any Louisiana agency, program, or service as well as providers. We are open and available to coordinate with and perform outreach to, the Department of Children and Family Services when they are involved with an enrollee and family and encourage participation in ICT meetings. Providers have a dedicated case management referral box for assistance, and we share the POC and engagement in ICT meetings with providers and state staff as applicable. With enrollee permission, Providers can log into CommunityCare, our enrollee management system, to view care plans for their patients to improve care coordination and reduce any duplication of services. Our team identifies support coordination agency involvement and collaborates and coordinates care for enrollees who receive services though these agencies to avoid duplication of efforts.

2.6.6.6 If the Proposer intends to establish a delegated case management program as described in Attachment A, ...

Delegated Case Management in Louisiana

[redacted]

We will continue to work with providers who would like to explore delegated arrangements, when it makes sense for both parties. Keys to successful delegation include strong communication channels, clear expectations for case management operations and outcomes, and staff collaboration. Our criteria includes standards such as: able and willing to take on meaningful downside risk; demonstrated experience/success with risk with UnitedHealthcare and/or other plans; sufficient licensed, trained and knowledgeable staff; prepared to assist and share data for operational, regulatory or accreditation audits. UnitedHealthcare continuously supports the delegated relationship through annual and/or quarterly clinical assessments and reviews to drive improvements across clinical, claims, provider data, and solvency. We offer ongoing relationship development and oversight with channels such as UnitedHealthcare training, addressing regulatory or performance gaps, and regular communication touchpoints. We will continue to work with our provider network to identify others who are prepared and enthusiastic to partner with us in a delegated arrangement.

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2.6.7 Case Scenarios [5-page limit per scenario]

The Proposer should provide its approach to serving Enrollees through its response to case scenarios. As part of …

2.6.7.1 The Proposer has an enrollee who is a 5-year-old boy who is noted to have several active medical issues …

Advance Health Equity

Despite the efforts of his PCP and caregiver, this 5-year-old boy who we will call E.A., doesn't have a diagnosis to explain his symptoms and is not receiving the care he needs to reach his full health potential. We will move quickly to work with his PCP and caregiver to understand and overcome the barriers that have been keeping him from completing his psychiatry, neurology and otolaryngology appointments such as transportation or family and work obligations. As part of our assessment, we will seek to understand if E.A. and his caregiver are members of a minority community that has experienced institutionalized racism and bias that affects the caregiver's engagement with health care. We will connect the family to tools at home and school to better support them.

Through the many systems we have in place to identify individuals who need case management, we can identify and support members like E.A. as their conditions and needs change. Upon identification, we will create an interdisciplinary care team (ICT) to support the member and his family. This includes partnering with his PCP as the "hub" of care and connecting him to the "spokes" of Louisiana specialty providers and other supports, including, as needed and if appropriate, telehealth and telepsychiatry. Our case management will support the PCP in care coordination efforts, building on the relationship between the PCP and the family.

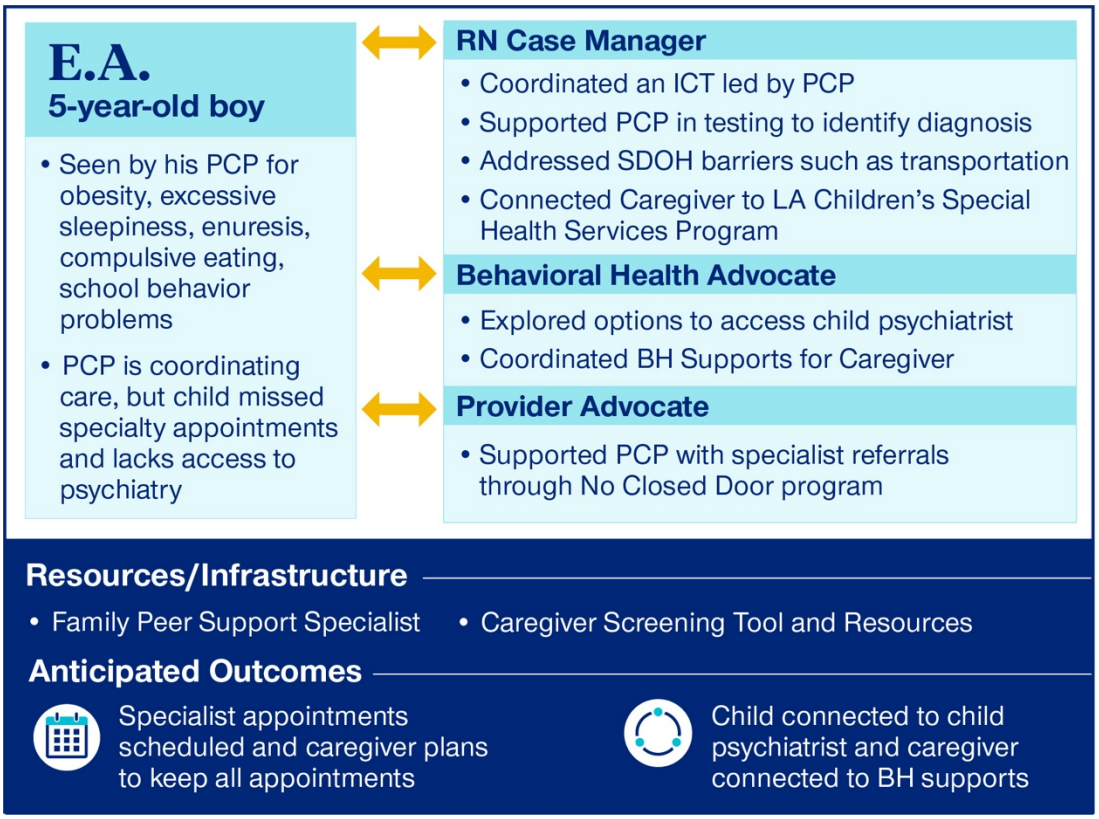

Figure 1. Case Management Strategy. Our whole person, integrated case management model addresses medical, behavioral and social issues.

2.6.7.1.1 Describe what systems the Proposer will have in place to identify this enrollee as having persistent and …

Identification of Our Enrollee and His Needs

We have multiple systems in place to identify E.A. as having persistent and untreated medical and behavioral issues. We would identify him through any one of the following processes:

- Our predictive algorithm, Impact Pro, which analyzes demographics, medical, behavioral, pharmacy claims and social determinants of health (SDOH) indicators, risk stratifies him as high risk. The algorithm uses more than 300 clinical indicators to identify enrollees with gaps in care, high utilization, risk markers and condition-specific triggering events. These indicators also include the flexibility to incorporate age bands into our algorithm to prioritize younger enrollees for outreach.
- E.A.'s PCP or other provider calls enrollee services or emails the case management department directly to request support and refer him to case management. We provide information about how to make referrals to case management on our provider portal, in our *Care Provider Manual* and during provider relations meetings.
- E.A.'s caregiver calls enrollee services and requests case management services or calls our NurseLine and is referred to case management. We provide information on how to engage with case management in our *Member Handbook* and on our member portal.
- We use claim(s) to identify certain codes which individually or in combination with others such as behavioral health conditions, SDOH needs, and physical conditions, identify E.A. as having special health care needs. Even if the claims took place when the child was enrolled with another MCO, we will capture information when we review historical claims data or from a transition report sent by his previous MCO.
- When outreaching to E.A. and his caregiver for an initial Health Needs Assessment (HNA) upon their enrollment, we include questions on current health care and any risks or concerns.
- E.A.'s resource team at school can make a referral to case management as well to help coordinate care and services to support school interventions.

2.6.7.1.2 Describe what process the Proposer will have in place to ensure that the enrollee has coverage of all …

Ensuring Coverage of Medically Necessary Services

By providing case management, we can help identify needed services and provide close monitoring of coverage determinations. We cover all medically necessary EPSDT services for children and verify determinations are made on medical necessity without consideration of cost or presence of the requested service on the fee schedule. One of the primary responsibilities of the case manager (CM) we assign is to help E.A. and his caregiver navigate through these processes to explore options and opportunities for E.A. to get needed care. Collaborating with utilization management, our CM can help E.A.'s caregiver file an appeal if they receive an adverse determination on a service request. Our CM will help E.A.'s caregiver submit a member-initiated organizational determination (MIOD) if their provider refuses to submit a request for medical necessity review on their behalf. The CM will attempt to find an in-network provider but will search for an out of network provider and enter into a single case agreement (SCA) if necessary.

Integrated Case Management

Due to his obesity, his age, medical and behavioral health conditions, and lack of engagement with specialists, E.A. is identified for Tier 3 (high risk) case management and assigned an RN case manager (CM) and a family peer support specialist (PSS) with training in whole-person health care (described above). A behavioral health advocate (BHA) will provide additional support, and the RN CM will serve as the primary contact for E.A., his caregiver and PCP. With empathy and compassion, the CM will work to build a trusting relationship with E.A. and his caregiver — listening to understand and to support the development of this relationship, the CM will offer to visit E.A. and his caregiver in in the location of their choice.

Family Peer Support Specialist (PSS)
The PSS provides support to families and caregivers caring for youth identified as having a serious emotional disturbance (SED) or co-occurring disorder and help the entire family in their recovery.

The PSS is a parent or adult caregiver, with experience, specialized training, and who has an understanding of another parent's situation via the shared emotional and psychological challenges of raising a child with SED. The PSS establishes a connection and a trust with the enrollee and family not otherwise attainable through other service relationships (e.g., counseling, psychologist, minister) because of their shared experience.

We recognize E.A.'s family has a relationship of trust with their PCP and our CM will work with the PCP and caregiver to determine how we can best engage in supporting the child's care. If a HNA has not previously been completed, the CM will begin by engaging with the caregiver to complete it, including screening for SDOH needs. Our CM team will work closely with utilization management as needed to account for medically necessary services not on our fee schedule or covered by the state that should be covered under EPSDT. Our CM teams receive training on Louisiana-specific medical, behavioral, and pharmacy benefits, value-added services, programs through WIC, OCDD and OASS and how to access these benefits. Training is provided at orientation, with supplemental monthly and ad hoc training sessions.

The PSS will build on their experience to establish a connection with the caregiver, understand their experience, help recognize and resolve problems contributing to the caregiver's ambivalent adherence to treatment plans, and offer their support to the caregiver as they navigate this difficult situation.

Supporting the Enrollee's PCP in Coordinating Care

E.A.'s PCP will continue to lead care for the enrollee, serving as the "hub" and supported by the "spokes" of specialty providers and other supports. If the caregiver chooses, the CM or PSS will accompany the child and caregiver to any appointments. For the child psychiatrist and developmental pediatrician, if the PCP recommends one, we will arrange for appointments, transportation and any other needed supports to help the caregiver keep those appointments. The CM coordinates with the PCP and developmental pediatrician as available to complete a comprehensive assessment, including screening for autism and identification of all conditions requiring treatment or ongoing care.

The CM will convene the ICT care pod, which comprises E.A., his caregiver, the CM, a behavioral health advocate (BHA), PSS, the PCP and any other involved providers, to develop an individual plan of care (IPOC) for E.A. In addition, the CM will encourage the caregiver to include anyone else they feel can contribute, such as a teacher, a supportive friend or relative, OCDD, DCSF if the caregiver is a foster parent, and any other agency. The ICT will conduct integrated rounds to discuss E.A.'s case. If E.A. needs a comprehensive multi-specialty assessment, we will cover travel expenses, including

meals and lodging, as appropriate, to a multi-specialty providers such as Ochsner Hospital for Children, Children's Hospital New Orleans, or Our Lady of the Lake Children's Hospital.

Physical Health Services

With the caregiver's permission, the CM supports the PCP as the hub of the child's care as they:

- Arrange for another referral to and follow up with a neurologist to study possible neurological sleep disturbance at a multi-specialty center or with our contracted specialist, Dr. Pena-Miches, a neurologist in Monroe, who offers in-person and telehealth visits throughout Louisiana
- Arrange for genetic testing if recommended by any of the specialists to identify possible genetic contributions to E.A.'s symptoms
- Arrange for an assessment of whether endocrinological issues, including diabetes, may be contributors to the child's excessive sleepiness, enuresis and behavioral issues
- Assess and oversee treatment for E.A.'s enuresis
- Make new appointments for otolaryngology
- Make appointments and procure coverage for neuropsychological testing at a multispecialty center, or multispecialty neurology practice
- Manage the child's obesity using the *Childhood Obesity Treatment Toolkit for Louisiana PCPs* produced by Pennington Biomedical Research Center and refer him to Pennington to explore other opportunities for treatment

Children's Special Health Services Program
The CM will identify any other State programs that can provide the family with supports and services, including the LA Children's Special Health Services (CSHS) program. For example, if he were eligible, some of the CSHS clinics offer genetic testing among their services. If E.A.'s PCP has not completed a developmental screening, the CM will coordinate to complete the screening using the LA Developmental Screening Toolkit.

Behavioral Health Services

To address the lack of a child psychiatrist in the family's area, we will explore both in and out-of-network options and, if there are no in-network options, enter into an SCA with a local child psychiatrist or, if travel is a caregiver concern, use a hybrid telepsychiatry model for periodic face-to-face visits with a child psychiatrist and local provider telehealth sessions in between. If the PCP and caregiver determine telepsychiatry is the best option and the family needs a smartphone to access this telemedicine service, our CM will arrange with our Assurance Wireless partner for a smartphone to be provided. We would arrange non-emergency medical transportation (NEMT) for the child and caregiver and help overcome any other barriers to fulfilling the periodic face-to-face appointments.

To address E.A.'s aggression, elopement and other problematic behaviors, and to support the caregiver, the child psychiatrist will refer the caregiver to a provider of an evidence-based program such as Positive Parenting Program (PPP), or Child-Parent Psychotherapy (CPP) available in the family's geographic area. We will provide NEMT for E.A. and his caregiver if needed. With the caregiver's permission, the case manager will coordinate with E.A.'s school regarding development and implementation of an Individualized Education Plan (IEP) if he does not already have one.

Caregiver Supports

The PSS will use the Caregiver Self-Assessment Questionnaire developed by the American Medical Association to assess E.A.'s caregiver for burnout and familiarize them with caregiver support

resources on the member portal such as articles on Caregiver Tips, Stress Relief and Steps to Getting Help, and links to support groups and otherl supports. In addition, with the caregiver's permission, his CM and PCP will refer E.A. to his regional OCDD waiver office for an evaluation of eligibility for services and the New Opportunities Waiver program, or other program as applicable.

Access to Other Benefits

We will use our vendor, Centauri Health Solutions, for help applying for SSI or SSDI benefits if appropriate.

2.6.7.1.3 Describe how the Proposer will assist the provider and the enrollee's caregivers with adherence to …

Exploring Barriers to Adhering to Recommended Referrals

To explore why the child has not previously completed appointments with specialists, the PSS will listen and interview to determine the causes of missed appointments. This will include discussing any barriers posed by SDOH needs such as transportation or difficulty getting time off work. Working with the CM and the PCP, the PSS will help the caregiver develop strategies to overcome those barriers and verify those interventions are noted in E.A.'s individual plan of care (IPOC). For example, if the screening finds transportation has been a barrier for specialty appointment, we will provide NEMT services to appointments or work with providers to use telehealth resources to provide care without the need for travel. If the family lacks internet access, we will arrange with our Assurance Wireless partner for the caregiver to receive a reliable smartphone for internet access. In case a lack of understanding of the services available to the enrollee has been a barrier, the CM and PSS will work with the caregiver to reinforce their understanding.

Enrollee and Family Education

Because we know it is likely E.A. and his caregiver are overwhelmed and in need of a better understanding of his conditions, the PSS will connect the caregiver to a NAMI local chapter near their home, to educational webinars available through the *namilouisiana.org* website, and to family resources at the American Academy of Child and Adolescent Psychiatry website. Our enrollee portal has valuable resources such as the Family Recovery and Resource Tool and Guidance on Managing the Stress of Parenting.

Community-based Resources

The PSS connects the family to support at the Family Resource Center and the Families Helping Families community resource specialist sponsored by the CSHS program. The PSS will also connect E.A. and his caregiver to the local Boys & Girls Club, YMCA or other nearby, accessible Community-based Organization (CBO) to encourage community integration and physical activity.

Support for Provider Referrals

Our Provider Advocacy team will outreach to the PCP to verify they are aware of resources to support referrals. Our Point of Care Assist® tool, built directly into the most common EMR systems, helps PCPs review prior authorizations and specialist directories in one place, along with pharmacy and other operational information. In 2018, we launched "No Wrong Door," a program to make the specialist referral process easier. Whether a provider calls into the provider services center or sends an email, our "No Wrong Door" team does the legwork of reaching out to specialists to confirm at least three options who are in network and accepting new referrals, and provides tentative appointment options.

2.6.7.2 The Proposer has an enrollee who is a 14-year-old male residing with his mother, his 6-year-old brother, …

Elevate Integrated Care

We will move quickly to help this family in crisis, knowing that while this youth, who we will call E.B., ideally needs to be reintegrated back into his family, school and community, he and his family must have proper supports and services to support their safety and give him the best possible chance at remaining at home. While reintegrating him back into his family will remain a key goal, our first priority will be safety. Our care team will engage with the hospital team, E.B.'s providers, his mother and, with the mother's permission, E.B. Together, they will quickly identify and implement alternatives to the hospital's plan, which is to discharge E.B. home while his mother feels unsafe and to threaten to involve DCSF. Once the short-term crisis is averted, we will make plans to bring him back home when appropriate. Our approach to addressing E.B.'s needs includes two phases:

Short Term – Responding to the Crisis: We need to put clinically indicated and medically necessary services in place to make sure E.B. and his family are safe and prevent the need for DCFS involvement, by planning for his discharge in a thoughtful and integrated manner.

Long Term – Support, Coordination and Connection: We need to organize and ensure clinically indicated and medically necessary services are in place to return E.B. to the community and successfully address the needs of the youth and the family there.

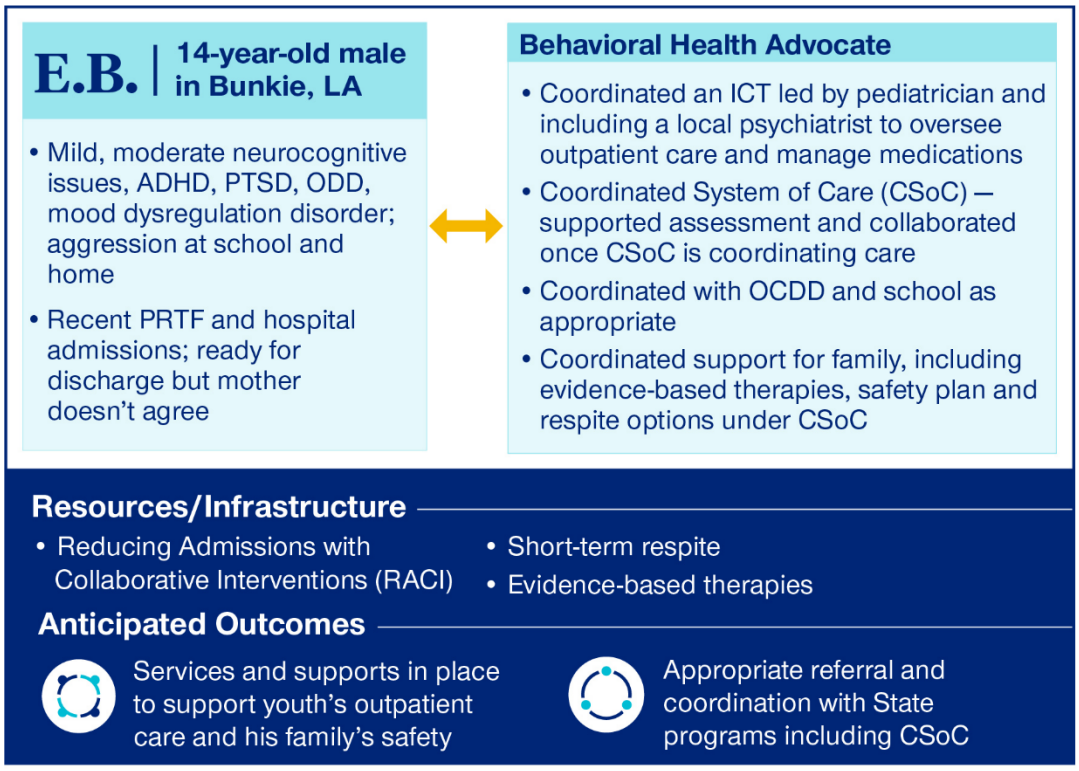

Figure 2. Case Management Strategy. We coordinate with CSoC to get him the care he needs.

Accessing Specialty and Evidence-based Treatment

High Intensity Care Management

This must be a tremendously scary moment for the mother since she fears for her family's safety, is aware that services for her son have so far been ineffective and is being threatened with a DCFS report for abandonment. When we learn about this situation, we assign E.B. a behavioral health advocate (BHA) as their case manager. Our BHA will provide Tier 3 (high intensity) case management, including transitional support between care settings and care coordination with providers. The BHA will be the primary point of contact for E.B. and his family, providers and agencies, working to build a trusting relationship with the member and family. Through our case management of individuals like E.B., we have been able to successfully shift care from inpatient settings to community-based behavioral health outpatient providers, providing a better experience for both the family and the member.

The BHA works with E.B.'s pediatrician to create an interdisciplinary care team (ICT) comprising E.B., his pediatrician, his Community Psychiatric Support and Treatment (CPST) worker and the Mental Health Rehab LMHP supervisor, outpatient providers, our behavioral health medical director, a utilization management representative, his mother, his OCDD worker (if applicable), and for a time, the hospital provider. The ICT will be expanded to include additional partners as they participate in his care.

Short-term Intervention

The potential escalation to DCSF creates unnecessary stress on E.B.'s mother. We will rapidly de-escalate this critical situation by immediately holding an ICT meeting with the inpatient provider. The ICT discusses extending days, the mother's and inpatient provider's concerns, and offers solutions until there is an agreed upon plan and services for a safe transition. We will reassure and work with E.B.'s mother and her son's providers to verify services and supports are in place before E.B. is discharged to make sure both he and his family are safe.

Safety Planning

We will work with his mother, pediatrician, and behavioral health providers to develop a Wellness and Crisis Plan and verify the mother is comfortable with the plan. The plan will address behavioral skills for the family to help mitigate stressors that contribute to his outbursts. It will help his mother to know who to contact in case of a crisis.

Short-term Intervention: Immediate Referral to Coordinated System of Care

We believe the best option for treating E.B. is Louisiana's Coordinated System of Care (CSoC). If the ICT believes he may be eligible for CSoC, our BHA will work with the PCP to present that option to his mother. If she agrees, we will conduct a warm transfer phone call with the mother and Magellan Health, the CSoC managed care organization, to conduct the brief screening. Our BHA will request an expedited assessment. We will verify he is linked to appropriate behavioral and physical health services while the wraparound agency (CSoC) completes the assessment to determine eligibility. We will continue to collaborate with Magellan Health to provide complete care for E.B. and his family. If and when he is determined eligible for CSoC, we will make sure Magellan has needed clinical information, including current services authorized. We will continue to manage his other behavioral

health needs during this time and will educate the mother about this service and the value of wraparound services.

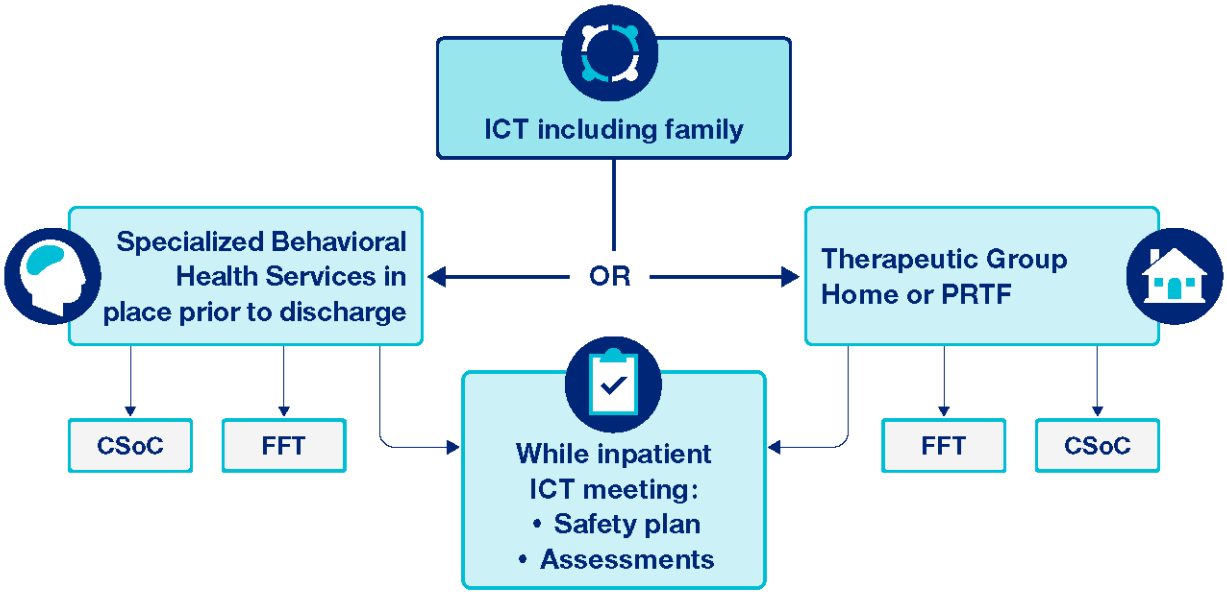

Figure 3. Options After Discharge. The interdisciplinary care team will work with the mother to discuss options for a safe transition.

Short-term Intervention: Deciding Safe Discharge Options

With his mother's consent, one option the ICT will consider is if there is a member of E.B.'s extended family who doesn't have young children in the home and might be willing to let E.B. temporarily live and receive services in their home. If that is not an option, the options for this youth include the following, listed in order of the family's preferences and clinical indications:

- **He returns home with necessary services:** To help his family feel safe, his BHA will arrange therapeutic behavioral services, such as CSoC, increased Community Psychiatric Supports and Treatment (CPST) hours, crisis planning and OCDD waivers (if eligible), outpatient Functional Family Therapy (FFT) or Multisystemic Therapy (MST), and medication management by a child psychiatrist, if eligible. See below for more about these services.
- **Therapeutic group home:** The BHA can place him for a temporary stay in a therapeutic group home (TGH) until returning home with necessary services.

Experience with Adolescents in Residential Care

We have extensive experience managing care for youth in residential care. Recently, a 13-year-old boy in Louisiana was admitted to a PRTF with a primary diagnosis of Schizoaffective Disorder Bi-Polar Type and Disruptive Mood Dysregulation Disorder after several behavioral health inpatient stays over 2019-2020 due to violent and aggressive behaviors. Our BHA began supporting discharge planning 60 days prior to discharge (rather than the contractually required 30 days prior), communicating frequently with the family to prepare for the enrollee's return home. The BHA remained engaged with the family, his PCP and behavioral health providers after discharge. He went home in April 2020, remains at home, and adheres to his recommended aftercare.

- **Psychiatric residential treatment facility (PRTF):** This is the last option, whereby E.B.'s mother would voluntarily admit him to a PRTF.

Short-term Intervention: Assessment for Specialty, Evidence-based Treatment

The BHA will conduct an HNA and a comprehensive assessment and share results with the ICT to confirm a shared, full understanding of E.B.'s situation. The ICT will identify additional assessments needed, including a neurocognitive assessment, and decide if these should be conducted while E.B. is an inpatient or in the community. If comprehensive assessments are needed and not locally available, the ICT can work with a nearby multi-specialty hospital in Alexandria to conduct the assessments. We will facilitate necessary and appropriate transportation through the NEMT benefits.

If E.B. has an open case with OCDD, the BHA will coordinate with the service coordinator. If not, the BHA will coordinate with the Central Louisiana Human Services District, which serves Avoyelles Parish, to get an urgent evaluation. If E.B. is approved for a waiver program, they can request a support coordinator to help with obtaining local resources. The support coordinator will be included on E.B.'s ICT. The ICT will consider asking OCDD to facilitate a behavioral consultation with one of their 35 trained independent behavioral consultants while inpatient, or upon discharge.

Options After Discharge: Accessing Specialty Treatment

Returning Home with Necessary Services

We will work with the ICT to engage Dr. Nabil Gad, a psychiatrist in Marksville, 17 miles from Bunkie, or a child and adolescent psychiatrist in Alexandria (33 miles), to coordinate E.B.'s care after he is discharged from the hospital or from a PRTF or residential setting. Based upon the psychiatrist's recommendations, we will monitor CPST's increase in the frequency of services. The psychiatrist will manage his medications, with medication adherence tracking provided by our BHA. Our BHA will use the Rx Claims platform to identify and resolve pharmacy issues. E.B's BHA will remain engaged with him and his family to adjust services to promote E.B.'s continued tenure in his community.

Linking to Evidence-based Therapy

We will work with his providers to initiate evidence-based Functional Family Therapy (FFT) at Care For You Social Services, LLC or Multisystemic Therapy (MST) provided by Life Changing Solutions LLC for Avoyelles Parish. We will work with the family to provide transportation and other supports to make sure E.B. and his family can participate together in family sessions, whether he is home or in a residential placement. If and when recommended during the youth's ongoing care, the ICT, including CSoC and the child psychiatrist, will identify a Youth-PTSD (CBT) treatment provider.

Step-down to PRTF or Therapeutic Group Home

Two options the ICT will consider as they work on a plan to prevent DCFS involvement and reassure E.B.'s mother about her safety concerns will be an additional inpatient hospital day(s) while crisis and discharge planning are completed. Depending upon ICT recommendations, we may approve a short-term placement in a therapeutic group home or PRTF if medical necessity criteria are met and assist locating a PRTF facility close to home such as Methodist Children's Home or New Way of Southwest Louisiana. The ICT will be expanded to include external partners as they participate in his care. If he is placed into a PRTF setting, we will start discharge planning 60 days prior to PRTF discharge and confirm mother's involvement in family therapy. After the immediate crisis is passed and E.B. is stable we will conduct a root cause analysis to determine how his case escalated to repetitive crises. These lessons learned may shape future engagement.

2.6.7.2.2 If/when inpatient or residential level of care is recommended for more intensive treatment and safety, …

Addressing Enrollee and Family Service Needs

To help E.B. transition home and remain stable given his prior history, if he is admitted to a facility participating in Reducing Admissions with Collaborative Interventions (RACI), we will enroll him in the RACI program, an interdisciplinary approach for decreasing acute behavioral health readmissions (i.e., frequent behavioral health inpatient admissions) and increasing community tenure for individuals with complex needs. Since its implementation in 2020, RACI has resulted in improved communication with inpatient staff, goal-focused collaboration that has broken down silos of care, proactive identification and management of individual's needs, and improved provider relationships.

If E.B. doesn't return home immediately, but is first placed in a TGH or PRTF, our BHA will schedule recurrent meetings that include E.B., his mother and his ICT. During these meetings, they will discuss E.B.'s needs related to neurocognitive and behavioral health diagnoses. The ICT and his BHA will confirm the TGH or PRTF are teaching his family skills to help mitigate stressors that contribute to his outbursts and that they understand E.B.'s therapy needs and know who to contact in case of a crisis. To begin practicing skills and normalize family relations, E.B.'s care team will support and help organize therapeutic passes as recommended by the residential treatment team. This level-setting promotes successful transition to the family and extended community tenure. The BHA works with E.B.'s family to continue any supports necessary for continued outpatient treatment.

Coordination with CSoC

If E.B. is enrolled in CSoC prior to his discharge from the hospital, CSoC provides family support and services and our BHA will coordinate those services with CSoC through rounds with Magellan. If he is not enrolled in CSoC or if he has not yet been found eligible for CSoC, our BHA will work with E.B.'s ICT to make sure such family support and services are in place.

Parenting Supports

We will offer short-term respite for E.B.'s family. When he is engaged with CSoC, respite will be part of the services, and we can offer respite outside of CSoC if needed. While in CSoC, the family will receive services from a Family Service Organization, including Parent and Youth Support and Training and Independent Living and Skills Building. If eligible, OCDD can offer additional support through their Children's Choice or New Opportunities Waiver. The BHA will explore if there are supports, we can put in place to help the mother in her continued employment.

Mentoring

We will assist CSoC with obtaining resources for mentoring programs for youth such as the Big Brothers program, scouting, a sport program or faith-based programs for youth and families.

School Supports

The BHA will contact E.B.'s school and coordinate to develop and implement an IEP if one is not already in place. The BHA will facilitate communications between E.B.'s teachers and his behavioral health providers regarding performance, behaviors and behavioral interventions at school.

2.6.7.3 The Proposer has an enrollee that is a 17-year-old girl who immigrated to New Orleans to live with her …

This 17-year-old, who we will call E.C., and her newborn child have endured significant trauma, and her daughter is in an extremely fragile state. We will address how we will provide supports as the child is hospitalized for diabetes insipidus and DNR orders are placed, but we will begin by explaining how we will provide case management throughout her pregnancy and immediately after delivery. Our Healthy First Steps (HFS) maternal and infant care management model supports E.C.'s needs during and after her pregnancy and extends to support the mom-baby dyad upon her baby's birth. We will approach her and her family with compassion and sensitivity, communicating with her in her native Spanish as we help her navigate care for herself and her newborn with complex medical needs. Our HFS case managers currently serve individuals in Louisiana of all different races, backgrounds, ethnicities and languages spoken, and are trained to support and empower mothers and infants who experience significant emotional, physical and social challenges.

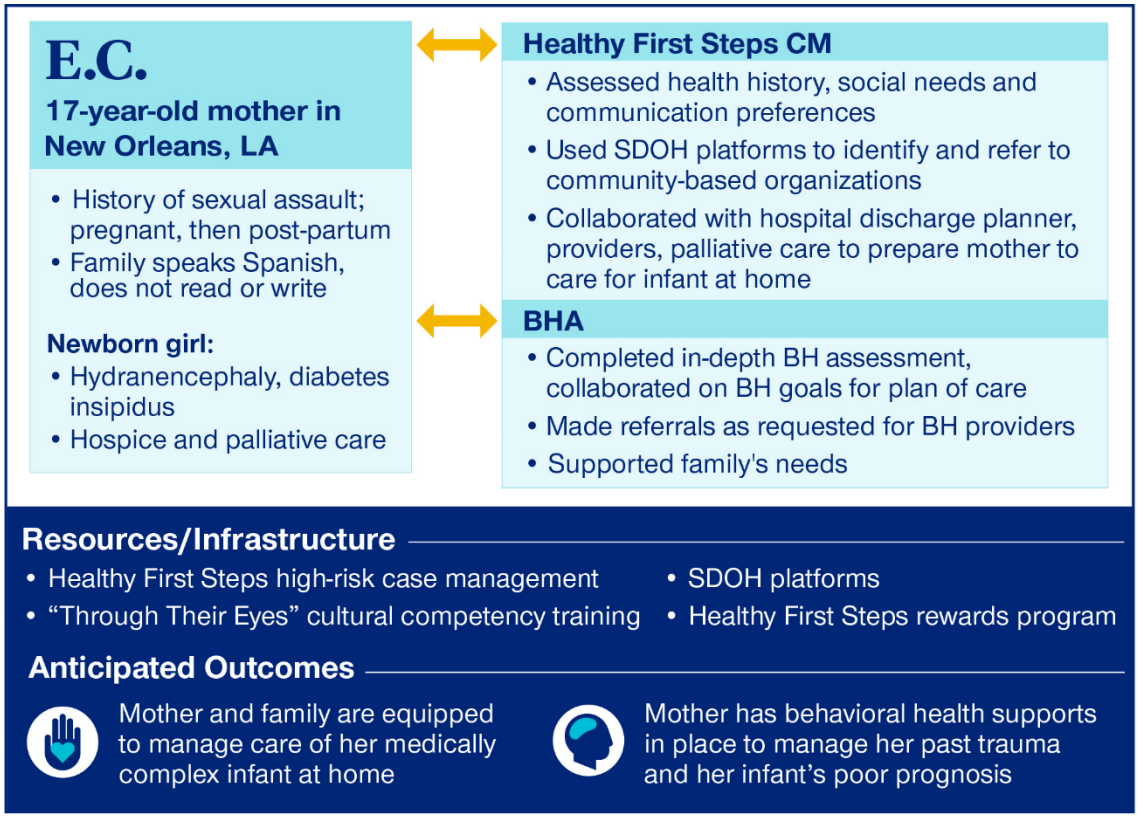

Figure 4. Care Management Strategy. Our Healthy First Steps (HFS) maternal and infant care management model extends to support the mom-baby dyad upon her baby's birth.

2.6.7.3.1 Describe how the Proposer will provide care management for both the medically complex infant and her …

Healthy First Steps (HFS) Maternal and Infant Care Management

Our trained staff begin their support of E.C. during her pregnancy, providing resources and coordination to meet her complex needs, and continue that support after her infant is born.

During Pregnancy: Early Identification and Outreach

Our team identifies E.C. as early as possible and assess her needs to ensure she gets connected to appropriate and timely prenatal care. For example, timely ultrasounds might identify the infant's hydranencephaly before birth, allowing E.C. and her family to prepare for this difficult diagnosis. We

use all information available to identify pregnant enrollees as quickly as possible, including, but not limited to, eligibility files, claims data, inpatient admissions, laboratory results, a Notification of Pregnancy (NOP) forms, or through a claim for a pregnancy-related medication.

Once E.C. is identified as pregnant, a Spanish-speaking maternity specialist on our Hospitality, Assessment and Reminder Center (HARC) team conducts a Maternity Initial Risk Evaluation (MIRE). Given she is a pregnant adolescent with complex behavioral, health and social needs, E.C. qualifies for Tier 3 case management. She is referred to a HFS nurse case manager (CM) who meets E.C. at her home or in the location of her choice to conduct a detailed HFS Clinical Assessment and collaborates with E.C. and her ICT to develop an individual plan of care (IPOC).

During Pregnancy: Comprehensive Assessment to Understand Her Needs

During the comprehensive assessment, we note the family's communication preferences. Since E.C. and her family don't read or write in either English or Spanish, we will use in-person, verbal communication in Spanish for education and outreach. Our HFS CMs are nurses with obstetrical experience, trained in evidence-based practices such as trauma-informed care, adverse childhood experiences (ACEs), motivational interviewing and harm reduction. This training helps us better engage E.C. so she might be comfortable sharing details, such as her sexual assault history and any other needs that may influence her birth outcomes. The HFS Clinical Assessment gathers data about her past and current medical, obstetric, behavioral health and social needs, including engagement in prenatal care. Questions will specifically address her home environment and support system, including the role her father and brother will play in the lives of E.C. and her infant.

During Pregnancy: Developing an Individualized Plan of Care

After the comprehensive assessment, the CM will coordinate with E.C. and her ICT to develop a plan of care to make sure she receives needed education and any medical, behavioral or social support. Because E.C. is 17, we will address all routine EPSDT requirements and make sure she receives all medically necessary services. Given her incredibly complex situation (i.e., sexual assault history, adolescent pregnancy, recent immigration status) her IPOC may include the following:

- We may recommend she receive extra support to help navigate her pregnancy, such as Healthy Start New Orleans, one of our community partners who provides in-home visits and resources to mom and baby for up to 18 months postpartum. Healthy Start has a Spanish-speaking community health worker who will help make sure she stays connected to her obstetric care and offer a variety of other supports.
- Given her history of sexual assault, with her permission we will connect her to trauma informed counseling through the New Orleans Family Justice Center which provides a range of services to survivors of sexual assault in Spanish.

Supporting E.C.'s SDOH Needs

Our HFS CM will connect E.C. and her family with local resources to address unmet social needs through our SDOH Resource and Referral Platform, tracking and confirming the referrals to make sure she gets the services she needs. For instance, she may not have a stable income for food resources or basic baby supplies, so we can connect her with Crescent City Family Services. Their Spanish-speaking staff can help her with WIC enrollment, obtain clothing and personal items, and

Luke's House and CCFS
UnitedHealthcare gave a $20,000 grant to Crescent City Family Services and $5,000 to Luke's House to enhance and develop initiatives for Spanish-speaking pregnant women in the Greater New Orleans and Baton Rouge areas.

access their onsite food and diaper banks. If consistent phone access is a barrier to engaging in needed services, we can offer a smartphone through Assurance Wireless. The HFS CM can assess E.C.'s education status and connect her with resources to finish her high school education if she has not yet completed it. For example, the CM could connect E.C. to English as a Second Language (ESL) and High School Equivalency Diploma (HiSET) preparatory courses at Delgado Community College. E.C.'s CM will coordinate transportation for E.C. to her medical appointments and, after her infant is born, to the infant's medical appointments.

As we continue building trust with this adolescent mother, she may share more about her immigration experience and request help with obtaining legal services. We can connect her to a legal aid service, such as the Pro Bono Project, an organization that provides free legal aid to low-income people and serves enrollees in New Orleans. The Catholic Charities Archdiocese of New Orleans provides legal services to immigrants and refugees and case management and counseling for crisis, stress, anxiety, cultural orientation, and English as a Second Language (ESL) and citizenship classes for families available in Spanish. If relevant, the Pro Bono Project or Catholic Charities may connect her to Luke's House Clinic's asylum clinic to provide forensic evaluation of her case if she is seeking asylum due to trauma and assault occurring in her home country.

Postpartum: Mom-baby Dyad Case Management

Our HFS CM provides ongoing case management support for E.C. and her daughter throughout the postpartum period, including education and resources on the importance of postpartum care for mom, well-child visits for infant, family planning resources, breastfeeding, postpartum depression, newborn safety and more. When E.C.'s daughter is admitted to the NICU upon birth, E.C.'s CM will pivot quickly to serve the family and engage the new mom-baby dyad in support tailored to the more pressing issues at hand. They will address these pressing issues during ongoing face-to-face meetings with E.C. and via telephonic consultation with the hospital discharge planner. There will be no change in her CM after she gives birth, providing consistency and continuity.

Preparing for NICU Discharge: Case Management for the Mom-baby Dyad

After E.C.'s baby is born and transferred to the NICU, E.C.'s CM will manage both the infant's NICU stay and E.C.'s postpartum care. Her CM and a HFS utilization management nurse will collaborate with E.C.'s existing ICT (including any behavioral health clinicians, family supports such as her brother and dad if she chooses) and any new members of the ICT, such as neonatologists and palliative care providers to reassess the needs of E.C. and her infant and develop an updated IPOC. The IPOC will address E.C.'s new goals for herself and her infant, understanding the significant trauma of the terminal hydranencephaly diagnosis. We will support E.C. in understanding the diagnosis and communicating with the many specialists she may encounter (e.g., neonatologists, a palliative care team, an endocrinologist) in her child's care journey.

NICU Discharge and Postpartum Supports

Prior to discharge from the NICU, we will work with the discharge planning team to confirm E.C. understands the treatment plan and feels equipped to manage care of her medically complex infant. For example, if the baby needs a feeding gastrostomy tube (G-tube), we connect E.C. with the home health provider to confirm they explained how the G-tube works so she is comfortable using and maintaining the device. If she is engaged with Healthy Start, they might designate a Parent Educator to meet with her twice monthly and can offer counseling services as well. Our CM continues to support E.C. to confirm she can attend postpartum appointments and address her family planning

goals while meeting the care needs of her infant. Our case management of moms and their infants in the NICU has resulted in a 2.4 percentage point decrease in readmission rate since 2019.

Postpartum: Connecting the Enrollee to Behavioral Health

With the news of the terminal diagnosis of her child, in addition to her prior stress and trauma related to her sexual assault, teenage pregnancy, and immigration, we will encourage E.C. to accept a behavioral health advocate (BHA) as part of her case management team. The BHA, a licensed clinician, will use our Language Line for translation and complete an in-depth behavioral assessment to evaluate E.C.'s depression, anxiety and trauma. The BHA will collaborate with E.C. to add goals to her IPOC and, with her consent, make referrals to a behavioral health provider. Due to her infant's initial poor prognosis, we will offer to connect her to resources for grief support. For example, our partner Saul's Light offers grief support to NICU families facing an imminent loss, meal vouchers and travel assistance for NICU visitation, peer support and counseling services for Spanish-speaking families. Recognizing that this family has had several challenging events, our BHA will offer family counseling and coordinate it if the family agrees. If the family has transportation barriers that might otherwise keep them from participating in family counseling, we will use our internal exception process to allow more than one escort for E.C. to these appointments, so that both her father and brother can attend.

Saul's Light
Saul's Light used a $15,000 2020 grant from UnitedHealthcare to expand a peer support group for Hispanic mothers with babies in the NICU, including a virtual group and individual mental health counseling sessions.

Elevate Integrated Care

Addressing Infant Readmission and DNR Orders

When the baby is readmitted with diabetes insipidus, the readmission will trigger an automatic notification from the HFS utilization management nurse to E.C.'s HFS CM. The HFS CM will collaborate with the hospital discharge planner, the infant's providers (e.g., pediatric endocrinologist) and palliative care team to confirm the infant's care team is aware of the change in treatment plan, and the mother understands how to care for her infant at home safely.

Additionally, we will support E.C. as she makes difficult decisions regarding end of life care, particularly as it relates to interventions and treatment options. If E.C. chooses to have her father participate with her in decision-making, we will include him as well. We will provide resources to help E.C. understand the diabetes insipidus diagnosis and the infant's prognosis and support her in shared decision-making with the pediatric endocrinologist and palliative care team. We will make sure her questions are answered as the pediatric endocrinologist and palliative care team balance the infant's prognosis with appropriate treatment recommendations. Coordinating with the hospice and palliative care providers, we will confirm appropriate supports and referrals are in place, with the hospice team taking the lead to coordinate hospice-related services such as PDN or respite care. At the next home visit, the CM will assess E.C.'s home to identify any durable medical equipment (DME) the family might need for the infant's care and work with the infant's providers to get the proper DME in place. We understand this is a difficult time for the family, and will make sure efficient and effective medical, behavioral and social resources are available to help E.C., the infant, and her family, as they prepare to grieve the loss of E.C.'s child and plan for her future.

Ensuring Culturally and Linguistically Appropriate Services and Education

Given E.C. is a Spanish-speaking immigrant from a country with a different health care system, we understand she may have different cultural beliefs about health care, and we anticipate accessing perinatal care may be particularly challenging for her. To make sure all enrollees, including E.C. and her infant, receive equal access to perinatal care, we offer multiple modes of communication, language translation services, and train our staff and providers, to facilitate effective communication and offer equitable resources to all.

Communicating and Educating in Spanish

To overcome literacy and language barriers, her CM will make sure E.C.'s entire care team uses pictures, videos, and in-person demonstration to communicate with E.C. and her family. We will work with E.C., her ICT, and our community partners to confirm E.C. understands the treatment plan. Our bilingual community outreach specialist, who has relationships with organizations in and surrounding Orleans parish, will help inform the action plan. We offer access to medical and behavioral health providers in New Orleans who speak Spanish and both providers and staff will use our Language Line for Spanish language assistance. For example, we have 12 behavioral health providers in 24 locations in the New Orleans area. All our HFS case managers live and work in Louisiana, giving them an understanding of their local communities that is critical to effective care management.

Training Providers and Staff on Health Equity and Cultural Competency

We acknowledge that bias may contribute to unequal maternal and infant health outcomes. We educate all our Louisiana staff and offer Louisiana providers training to deliver a good enrollee experience. To educate on explicit and implicit bias, we developed an *Addressing Health Equity* training and partnered with the Centers for Disease Control and Prevention (CDC), Morehouse School of Medicine and the March of Dimes on an *Addressing Maternal Mortality* training. These offerings increase understanding of the importance of cultural sensitivity and the role of implicit bias on maternal outcomes. All our HFS case management staff have completed this training and will apply the teachings to interactions with E.C. Additionally, we are working with the National Birth Equity Collaborative to develop additional training for our maternity teams on the importance of birth equity and the role we play in meeting the needs of all individuals we serve. Finally, all our staff must complete our *Through Their Eyes* cultural competency training, which supports national culturally and linguistically appropriate services (CLAS) standards.

2.6.7.4 The Proposer has an enrollee who is a 49-year-old male. He has a history of brain injury, alcohol abuse, …

Elevate Integrated Care

This individual, who we will call E.D., is in chronic pain, sees his prior medical, behavioral and social stability theatened, and is at urgent risk of experiencing homelessness. We prioritize compassion in our response and begin by listening to him, acknowledging his chronic pain, coordinating with all members of his care team and supporting him toward recovery according to his needs and wishes. Our first priority is to make sure his needs are comprehensively assessed and to verify he has the supports and services needed to remain in the community. As we work with him, we will explore whether he has family or other social supports in his community and engage them in supporting his recovery and his continued tenure in the community.

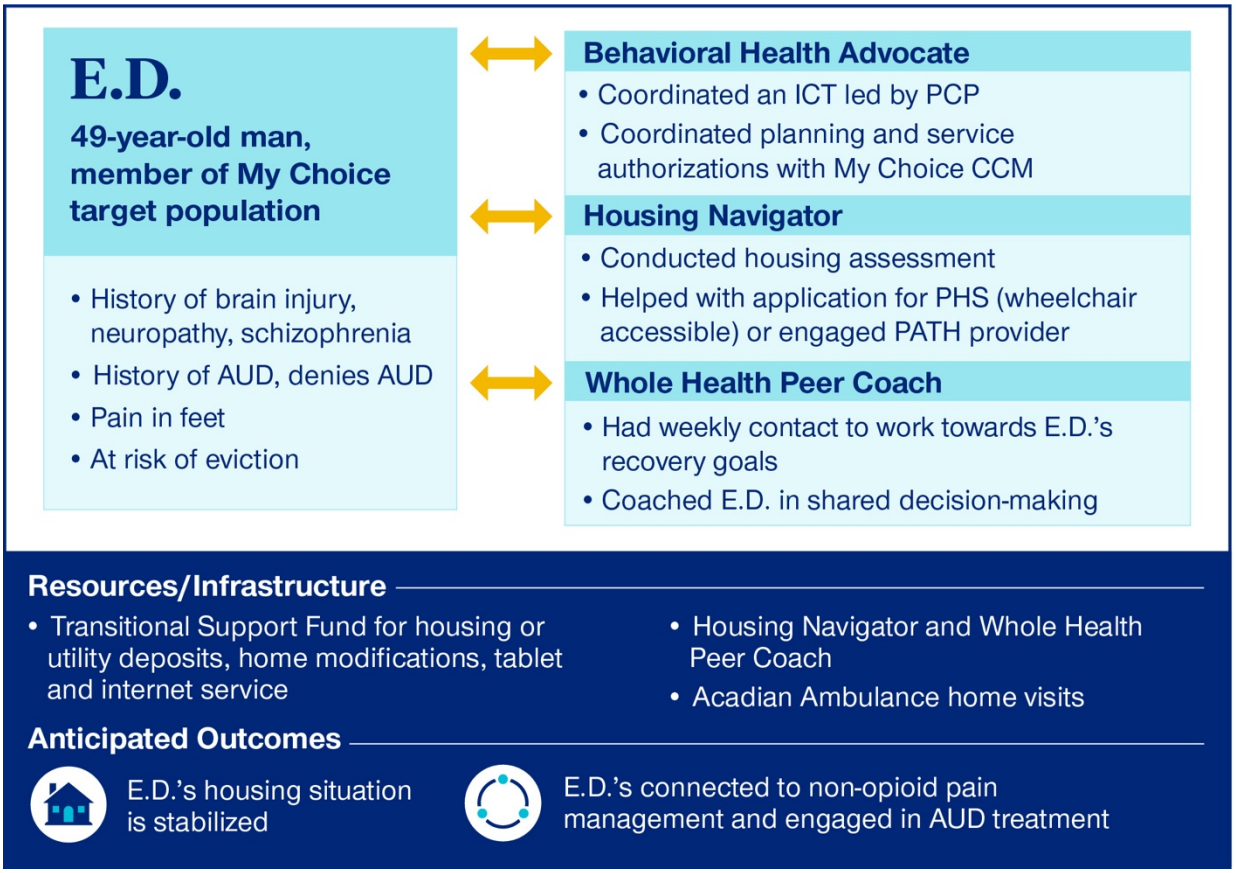

Figure 5. Case Management Strategy. We coordinate care with the My Choice community case management entity.

~~2.6.7.5.1~~ 2.6.7.4.1 How will the Proposer address this enrollee's needs?

Addressing E.D.'s Needs

Our approach to addressing E.D.'s needs includes two phases:

Short Term – Responding to the Crisis: We need to make sure E.D. is safe, with stable housing, and we connect him to the care he needs to address his chronic pain and alcohol misuse.

Long Term – Support, Coordination and Connection: We will work with E.D.'s My Choice community case management entity and his providers to support his comprehensive treatment goals and help him continue living in his community safely and to his full potential.

Integrated Case Management

Because E.D. is a member of the target population for the DOJ settlement or My Choice program for up to 12 months or more following his transition to the community, he receives CM services through our partner delegated community care management (CCM) entity. The CCM forms an ICT, including his PCP and neurologist; behavioral health providers, including an SUD provider who may offer MAT for his alcohol use disorder; HCBS Waiver services; any case managers assigned by providers; and our BHA and other resources.

While the CCM manages E.D.'s care, we monitor and participate in joint rounds and authorize additional needed services based upon medical necessity. We conduct performance reviews of the delegated entity to maintain oversight and confirm individuals receive needed services and supports.

DOJ Settlement and My Choice
We recognize E.D. is part of the target population for the DOJ settlement (My Choice) population and he desires to live in his community. The services and supports he currently receives are not sufficient to meet his needs and he is at-risk of returning to an institutional or residential setting or experiencing homelessness. We recognize the State intends for case management of his care to be delegated to a CCM once those are established in the state.

Our Oversight of Delegated CM
We will fulfill our oversight role of his delegated case management, collaborating with the CCM and his providers to develop a workflow that meets the state requirements and works for E.D. For example, if the CCM establishes an ICT, we will participate in ICT meetings and rounds and make contact at least weekly. We will designate a BHA as the single point of contact with the CCM to coordinate service requests and authorizations.

Assessment to Understand Needs

The CCM's BHA will review the discharge summary and aftercare plan from his previous admission with E.D. and use motivational interviewing to discuss what he thought worked or didn't work, and what his preferences are that may or may not have made it into the prior plan of care. This conversation, along with assessment results, will help inform E.D.'s new individual plan of care.

To address both the immediate crisis and long-term planning, his care team at the CCM begins with assessment to identify the factor(s) that are driving his alcohol use disorder (AUD) and his socially inappropriate behaviors, and his willingness to obtain treatment for his AUD. Those factors might include his chronic pain and his brain injury. In addition to a Health Needs Assessment (HNA), we will work with the CCM and his providers to confirm he receives:

- A behavioral health assessment to review his current treatment for schizophrenia, determine whether he is adherent with his antipsychotic medications, initiate treatment for AUD, and assess for additional SUD
- A neurology assessment of his brain injury, neuropathy, and initial assessment of chronic pain
- Follow up with a PCP, including screenings such as blood chemistries (he is at risk for cirrhosis), Hep C screening, cancer screenings and metabolic monitoring

As part of this assessment, his providers and case managers will explore whether he has family members or friends he wants to engage in his circle of support. Similarly, they will assess whether he has a previous case manager or nurse with whom he has had a stable relationship and, if so, if he would like to engage them in his care again. A disability assessment also will consider whether he needs a guardian to help him make decisions about his care.

Peer Coaching

If E.D. is willing, we will provide a Whole Health Peer Coach (WHPC) who has experience recovering from physical conditions, mental health conditions or substance use disorders and who has been trained in disease management. The WHPC will have at least weekly contact with E.D. via telephone or face-to-face, depending on his preferences, to work with him toward his recovery plan goals and help him navigate the CCM delegated case management process. The WHPC will attend rounds with the delegated entity ICT to help coordinate E.D.'s care.

Wraparound Services to Address the Behavioral Health Crisis

We will work with the CCM to present E.D. with several options for care. The WHPC will assist him in using shared decision-making to make a choice.

Forensic Assertive Community Treatment or Assertive Community Treatment

Through assessment, we will work with the CCM to see if he qualifies for Forensic Assertive Community Treatment (FACT) or Assertive Community Treatment (ACT) based upon his past forensic engagement, diagnosis, location within the state and frequent ED visits. FACT and ACT provide a community-based, wraparound service through a multidisciplinary team who can address his individualized, comprehensive needs.

Eleanor Health

If he declines or does not qualify for FACT or ACT and he lives in the Baton Rouge or Metairie areas, with the CCM we will assess whether he is a good candidate for Eleanor Health, an integrated provider specialized in treating co-occurring mental health and SUD. It provides comprehensive behavioral services, including medication-assisted SUD treatment and counseling; has mobile services and addresses social drivers of health needs. Even if E.D. already has an established SUD treatment provider, Eleanor can offer wraparound services. He can access peer support through Eleanor rather than using the WPHC. Eleanor Health's case manager will support his physical health needs and verify he is connected to his PCP and specialists. If he lives in an area not served by Eleanor Health and doesn't qualify for FACT or ACT, we will work with the CCM to arrange for virtual consultation between Eleanor Health, his behavioral health providers and PCP to make sure a full suite of services are available to meet his goals. If he lives in Baton Rouge, they may connect him with crisis services provided by RI International as an in lieu of service once approved by the State.

Stabilizing Housing

As we are working with the delegated CCM entity to put wraparound services in place, we will address E.D.'s insecure housing situation. If needed, we can offer support through our Transitional Support Fund to pay for housing or utility deposits for a new housing placement, or to modify housing to accommodate his wheelchair. We will refer him to our Housing Solutions Program which focuses on preventing evictions and homelessness. Our housing liaison will coordinate with his CCM to assess the options to stabilize his housing. They will discuss options for E.D., including:

- Contacting his current apartment manager to conduct a housing assessment and explore supports we can put in place to retain E.D.'s existing housing and avoid eviction
- Assessing whether he can qualify for Permanent Supportive Housing (PSH). If so, we will help complete his application for wheelchair accessible PSH. PSH through a qualified Mental Health Rehabilitation agency offers a supported environment where he can receive ACT and

other CPST tenancy services. If he qualifies, the PSH tenancy provider will participate on his ICT

- Engaging a Projects for Assistance in Transition from Homelessness (PATH) provider such as the Volunteers of America of Greater Baton Rouge or the South-Central Louisiana Human Services Authority, depending on his geographic location. PATH providers use federal grant funding to offer outreach and habilitation and rehabilitation services to individuals with serious mental illness who are experiencing homelessness

Physical Health Services

If E.D. is not currently connected to a medical home, CM will help him select a PCP. Our *Provider Directory* includes an indicator of whether the facility is wheelchair accessible. If E.D. is interested, we may encourage him to seek care at an FQHC, which offers integrated medical and behavioral health care services. The PCP will coordinate medical screenings, including a liver function test, a Hepatitis C screening and confirm he is up to date on preventive care, such as a COVID-19 vaccination. If screening indicates Hepatitis C, we will connect him with the Hep C Free Louisiana initiative for treatment. His care team will arrange for a comprehensive disability assessment and assessment of his durable medical equipment (DME) needs, including needs that arise from changes in his housing placement.

Alternatives to ED Use

In addition to encouraging E.D. to use his PCP as his usual source of care, contact his PCP or case manager first, or use our NurseLine or behavioral health call center, available 24 hours a day, seven days a week, we offer innovative alternatives to ED use:

- **Acadian Ambulance:** If E.D. lives in a parish served by Acadian Ambulance, we can initiate a referral for their providers to work with him in his home. We are the only MCO currently making direct referrals to Acadian. They will assess him, do a telehealth physician consult and take him to the ED if necessary. Afterwards, they will share any results with E.D.'s PCP.
- **Ready Responders:** We can initiate a referral to this network of trained EMTs, paramedics, and nurses to visit him. They will connect with him via a telehealth consult to address his conditions, monitor prescription adherence, and evaluate his ED use risk factors. They will counsel E.D. on appropriate settings for health care and encourage him to use his PCP.

Addressing Chronic Pain

Because his care team is concerned chronic pain may be a contributing factor for his frequent ED visits and perhaps even his AUD, they make it a high priority to assess possible causes. The PCP refers him to a neurologist, who assesses his history of brain injury and neuropathy and makes recommendations for diagnosis and treatment of his chronic pain. E.D.'s care team supports the neurologist's recommendations on diagnostic tests such as metabolic testing to rule out diabetes, nerve conduction studies and imaging. After the assessment, we will authorize services, including an orthopedist or podiatrist, physical therapy, acupuncture and chiropractic care, if recommended, through our value-added benefit. In addition, our BHA will discuss the psychological aspects of his chronic pain and coordinate care between his behavioral health and PCP providers. We will help with scheduling appointments and removing other barriers to access and treatment, such as transportation.

The CCM team will work with E.D.'s PCP and contact one of our DME providers to evaluate his wheelchair fit to determine whether modifications to provide proper support and cushioning might reduce his chronic pain. Also, once his housing is stabilized, we will work with the CCM to assess his physical environment to identify and mitigate fall risks.

Behavioral Health Services for Support, Coordination and Connection

The CCM will bring any current or new behavioral health providers into an ICT or rounds or, if he qualifies for FACT or ACT or Eleanor Health, they will hold regular rounds. If he lives in a rural area or requires specialty care not available locally, we will connect him to behavioral health clinicians in Louisiana who can support his care via virtual visits, assisted if needed. If necessary, we will use our Transitional Support Funds to provide a tablet with internet access so he can access the virtual visits. We will connect him to a local Genoa pharmacy in coordination with his behavioral health providers to manage his schizophrenia medications. If appropriate, the Genoa pharmacy Meds to Members program can send his medications directly to his home to improve medication adherence.

Addressing Alcohol Use Disorder

Through his FACT or ACT team, E.D. will receive co-occurring MH and SUD services to address his schizophrenia and alcohol use disorder, including MAT and counseling. If he is enrolled in Eleanor Health, they will provide SUD services including mobile crisis services. If he does not live in Baton Rouge or Metairie, under our contract with Eleanor Health, they can provide telephonic consultation with another provider. We will work to understand his AUD, including his readiness for change, as his choice will affect his therapeutic and housing options. If he is not interested in seeking abstinence, we will engage with him using principles of harm reduction, seek treatment aligned with his preference and look for alternative arrangements like group homes or transitional programs. His WHPC will help him find a local SMART recovery or AA chapter and attend the initial meeting with him if he agrees. For AA meetings, we provide transportation as a value-added benefit.

Resources and Infrastructure

E.D.'s WHPC will use motivational interviewing to explore his interests and goals and help him identify work, recreational or volunteer activities he would like to pursue. For example, WHPCs working with Medicaid enrollees in New York have connected individuals to outlets including a local bowling league, YMCA swimming lessons, and part-time or full-time employment.

Vocational Rehabilitation or Assistance Applying for Disability

Either through his FACT or ACT team, or separately, if E.D. is interested in vocational rehabilitation services, his care team will refer him for an assessment. Through our Transitional Support Fund, we can offer funding for further education, including a GED or vocational or college coursework. If he is not able to work and has not been previously approved, his case management team will refer him to our vendor, Centauri Health Solutions, for help applying for SSI and SSDI benefits.

Community-based and State Resources

During initial assessment, E.D.'s care team will work with his neurologist to determine whether he is eligible for services under the Louisiana Traumatic Head and Spinal Cord Injury Trust Fund and help him with the application. If he lives in an area served by a head injury support group, such as the Amaze Brain Injury Support Group in Lafayette, his care team will help him connect. Once he is stable, if he lives in an area served by a local NAMI chapter and qualifies for participation, his care team will connect him to their Friendship Club and his friends and family to family-to-family mental health education.

~~2.6.7.6~~ 2.6.7.5 The Proposer has an enrollee that is a 42-year-old woman, who lives alone with 24/7 care through …

UnitedHealthcare ascribes to LDH's definition of health equity: when "every person in a community has a fair and just opportunity to reach their full health potential." The enrollee described in this case scenario, who we will call E.E., is not being provided a fair and just opportunity to reach her full health potential.

There are several quality of care issues identified here, and we believe we would have identified E.E.'s medical needs earlier and provided case management. Our predictive algorithm, Impact Pro, uses more than 300 clinical indicators to identify individuals with gaps in care, high utilization, risk markers and condition-specific triggering events. It also relies on a series of Impactable Case Management (ICM) Indicators, including Nursing Facility Warning Signs, developed from clinical guidelines and national experience. Once E.E. was identified as needing intensive intervention, we would have immediately formed an interdisciplinary care team (ICT) to address her needs.

Our approach to meeting E.E.'s needs will begin by listening to her. We will ask about her goals toward meeting her full health potential and then coordinate her care with her NOW support coordinator and all her providers. With her NOW support coordinator, we will first make sure she quickly receives a new wheelchair or her existing wheelchair is equipped with replacement parts and customized to fit her needs. After we address that critical need, we will work methodically and collaboratively with the NOW support coordinator to address E.E.'s comprehensive DME, medical and therapeutic needs. Our role will be to advocate with the NOW support coordinator for meeting her needs. If necessary, our case manager will, upon consultation with a health plan supervisor, support an escalation of E.E.'s care needs to the NOW support coordinator supervisor.

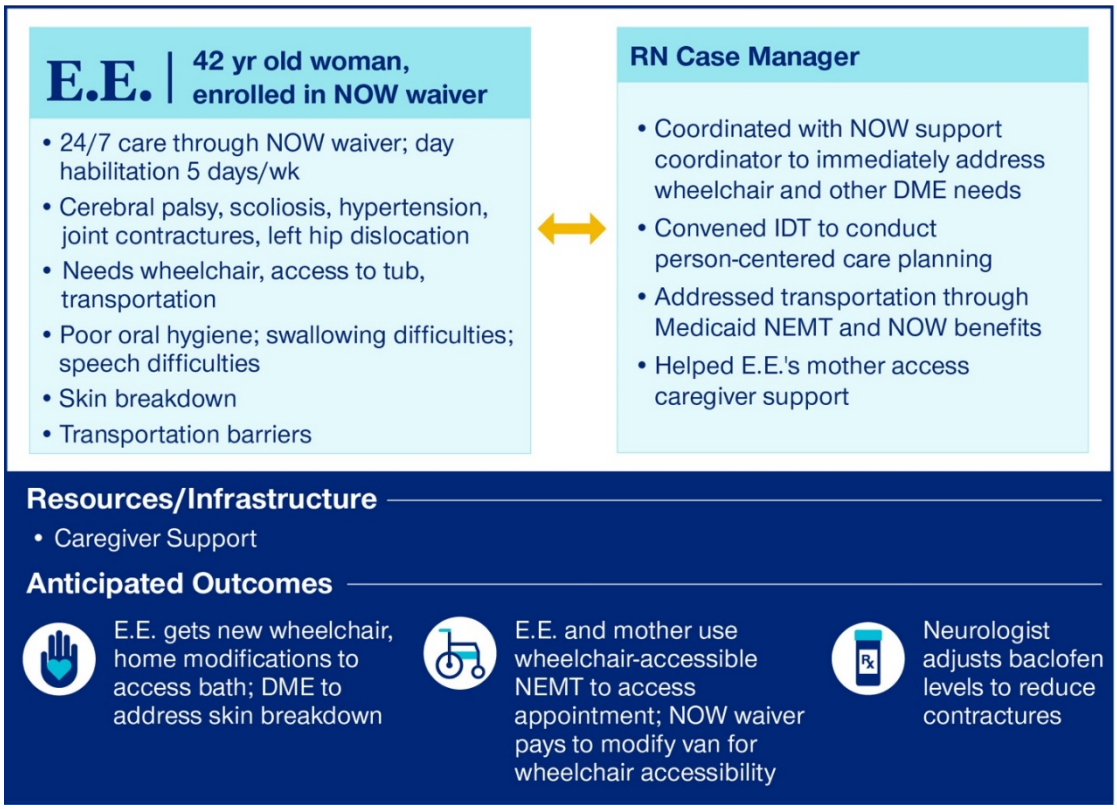

Figure 6. Case Management Strategy. We work collaboratively with the NOW support coordinator to address all DME, medical and therapeutic needs

~~2.6.7.7.1~~ 2.6.7.5.1 How would the Proposer address the various complex health care needs of this individual?

Addressing Complex Health Needs

Integrated Case Management

To address E.E.'s various complex health care needs and facilitate improved and timely access to services, we will assign her to Tier 3 case management with an RN case manager (CM). During in-person meetings, her CM will connect with E.E., her mother and her caregivers, who are with her on a daily basis, to build a deeper understanding of her complex needs and strength of her support system. Through an in-person visit, her CM will conduct an HNA and comprehensive assessment, including an assessment of her home to determine any additional DME and home modification needs beyond the urgently needed wheelchair.

Urgently Provide Wheelchair and Other Home and Vehicle Modifications

We serve over 350,000 members nationally who are receiving LTSS and our case managers are fully trained on NOW waiver coverage, so E.E.'s case manager is prepared to facilitate a productive conversation with the service coordinator and verify appropriate services for E.E. Our CM will coordinate with the NOW support coordinator to:

- Ask our specialty wheelchair vendor to conduct a standard assessment of her wheelchair to see if it meets her specific needs and determine whether it can be modified and repaired or if she needs a new wheelchair. Based upon that assessment, we will quickly coordinate her DME benefits available through the health plan and under the NOW waiver to get her a new wheelchair or to repair and customize her existing wheelchair
- Identify other DME needs covered by the NOW waiver including a communication device and a new mattress to prevent skin breakdown
- Identify modifications to her home, including her bathtub that are covered by the NOW waiver
- Identify modifications to the mother's vehicle that are covered by the NOW waiver, plan for any additional transportation benefits needed and available through the NEMT benefit and assess transportation benefits available to E.E. under the NOW waiver
- Assess and, if appropriate, arrange for home-based skilled nursing services and coordinate home health therapy services recommended by her providers, including speech therapy, physical therapy and occupational therapy

Interdisciplinary Care Team

To coordinate her services under the New Opportunities Waiver (NOW), our CM will gather an ICT and engage her NOW support coordinator to develop and implement an updated person-centered plan of care. We will collaborate to gain understanding about why key aspects of her care, such as DME or connection to providers, were not included in the individual plan of care (IPOC) or not acted upon and make concrete plans to address. The ICT will include E.E.'s providers, including her neurologist and orthopedist, any therapists she may see at adult day care, and E.E. and her mother if the mother holds medical power of attorney or if E.E. wants her participation. If the mother does not hold medical power of attorney, our care planning process will include helping E.E. develop an advance directive.

The care team will collaborate with the day habilitation provider to address care concerns, pulling them into E.E.'s ICT if appropriate. If there continue to be problems in quality of care, we will report the matter to the Office of Aging and Adult Services.

If E.E. does not currently have a PCP, the CM will help her select one and that provider will co-lead the ICT with her NOW support coordinator. Working with her PCP, our CM will take the lead in providing the services and supports not covered by the NOW waiver and make recommendations for services that can be covered and coordinated through the NOW waiver.

Addressing Her Needs with Urgency

If E.E.'s ICT recommends a short-term stay in inpatient rehabilitation or skilled nursing facility to address her urgent needs, including skin breakdown and contractures, we will approve the stay provided E.E. is in agreement. The ICT may recommend a palliative care consultation to make sure that we are optimally addressing the member's comfort and quality of life.

Physical Health Services

During our engagement with E.E., we will identify and address priority physical health services, including:

- Enrolling her in disease management and providing her a home blood pressure cuff for her caregivers to use in monitoring her hypertension
- Working with her PCP to arrange a physical medicine and rehabilitation consult with a physiatrist for a prescription for physical therapy if appropriate; we will provide transportation
- Addressing any DME needs discovered during the home assessment, including a new mattress and wheelchair customization if indicated
- Coordinating a speech therapy evaluation to address her undiagnosed swallowing difficulties
- Arranging for comprehensive in-home wound care of her bed sores by Restorix or another agency
- The ICT will confer with E.E. on her preference and make a recommendation to have her either continue to see the neurologist who practices 52 miles away, with transportation we provide, or to see a local neurologist. If necessary, we will implement an SCA so she can see a local neurologist who is not in our network
- E.E.'s CM and provider will work with the orthopedist to determine whether the member is a surgical candidate based upon medical necessity and whether benefit outweighs the risk for surgical intervention for the member

Behavioral Health Screening

Our CM will work with E.E.'s PCP to coordinate screening for anxiety and depression and coordinate any needed treatment or referral. We recognize that her challenges communication, pain from her inadequate DME, and social isolation may be risk factors for behavioral health issues.

Dental Services

Our ICT will coordinate E.E.'s dental care through the value-added benefits offered through the State's dental benefit vendors. Our CM will help E.E. access the NEMT benefit to arrange transportation to the dentist.

Caregiver Support

E.E.'s CM will coordinate with the NOW support coordinator to confirm E.E.'s mother is accessing the Monitored in Home Caregiving (MIHC) program. Through this program, E.E.'s mother can select a caregiver home provider of her choice. The caregiver home provider assigns a nurse case

manager and a social worker to assess the caregiver needs and develop a coaching plan to address those needs as she cares for her daughter. Needs may include education, access to resources, caregiver respite benefits and ongoing screening for anxiety and depression. If the mother is also an enrollee of our health plan, we will make her aware of additional benefits, including behavioral health care, available to her under Medicaid. On an ongoing basis, our CM will share any insights from the home with the NOW support coordinator to make sure comprehensive needs are met. If Individual and Family Support (IFS) is part of E.E.'s OCDD care plan, her CM will support coordination of that benefit.

Enrollee and Family Education

The CM will provide education for E.E.'s care staff and mother on how to transfer her without further harming her skin integrity.

We will connect her with a local affiliate of United Cerebral Palsy for supports and services. For example, the UCP of Greater New Orleans offers Supported Living Services, one-to-one services to assist with personal needs including daily life skills training, money management, transportation, socialization and recreation.

~~2.6.7.7.2~~ 2.6.7.5.2 How would the Proposer address improved access to the services and insure services are …

With E.E.'s ICT, our CM will work methodically and collaboratively with the NOW support coordinator to address E.E.'s comprehensive DME, medical and therapeutic needs. They will begin by developing and implementing an updated person-centered plan of care. Our role will be to advocate with the NOW support coordinator for meeting her needs. We would conduct a root cause analysis to understand the source of prior delays to E.E.'s care, ensuring that it is fully addressed moving forward.

~~2.6.7.8~~ 2.6.7.6 The Proposer has an enrollee that is a 13-year-old girl who recently presented for a sick visit to her …

Elevate Integrated Care

We will approach this case understanding that, in treating an eating disorder, we must address the needs of both the enrollee with the eating disorder, who we will call E.F., and her family. Addressing these needs starts with developing a comprehensive understanding of E.F.'s medical and behavioral background, and history of ACEs, if any, as well as understanding the family structure and supports. With E.F. and her parents' permission, we will further support E.F. by mobilizing natural supports preferred by the member and family. We will provide comprehensive education about eating disorders such as anorexia nervosa, making sure her circle of support recognizes the behavioral and medical aspects of the disorder and the acute and chronic components of successful treatment. We will build on the trusted relationship that E.F. and her family have with her pediatrician to make sure the care E.F. receives is integrated, addressing both medical and behavioral health aspects, and wrapping supports and services to make sure both the acute and chronic components of the needs are met.

~~2.6.7.8.1~~ 2.6.7.6.1 How will the Proposer address the acute and chronic components of this child's care needs?

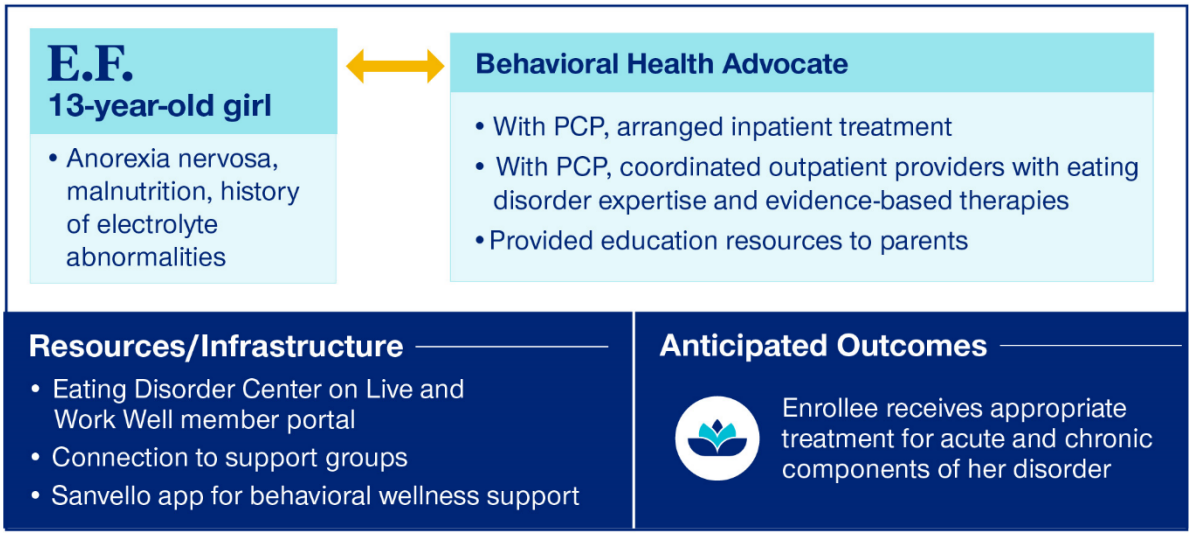

Figure 7. Case Management Strategy. We build on the trusted relationship that E.F. and her family have with her pediatrician.

Addressing the Acute Components of E.F.'s Needs

Integrated Case Management

Due to the urgency of this situation, we will assign E.F. to Tier 3 case management services and assign her a behavioral health advocate (BHA) as her case manager (CM). Her CM will bring the case to our integrated case management rounds and coordinate an ICT comprising the recent inpatient psychiatrist(s), her pediatrician, E.F. with her parents' consent, and her family to discuss recommendations.

Acute Services

The ICT, including the parents, will decide whether it is best for E.F. to receive inpatient treatment in a residential setting to address her acute needs, followed by outpatient services. The ICT team reviews with her parents and providers information about the out-of-state inpatient treatment center recommended to them, including whether it is in our network. If it is in our network, we will determine whether they would prefer to admit her there or to an alternative such as the Renfrew

Center of Florida, which has a residential program serving adolescents. Our CM will explain that we will cover all services that are medically necessary, regardless of cost or if it is a covered benefit. If the center recommended to them is out-of-network but is the only appropriate facility to meet her needs, we will negotiate a Single Case Agreement with the out-of-state, out-of-network provider. With either provider, we will cover travel expenses for the family.

The CM offers educational resources to E.F.'s parents on our member portal, specifically education about anorexia nervosa and how to choose the best treatment and support for their daughter. If the ICT recommends an inpatient stay, UnitedHealthcare 's medical director, psychiatrists and case managers communicate frequently with the residential provider and E.F.'s family to make sure the treatment follows standards of care, that the family is engaged in therapy sessions, and participates in discharge planning, and schooling is being offered.

While E.F. is in an inpatient stay, if the inpatient provider offers passes for her to take meals with family on or off campus, we will support that opportunity by offering transportation for the family to attend. This will support the family in practicing skills they have learned to help E.F. manage anxiety and cope during meals.

Addressing the Chronic Components of the Child's Needs

If E.F. and her family opt for a residential stay, after discharge we will continue to coordinate her care to address the chronic components of her needs. Our transitional case management approach, evaluated in a pre- and post-enrollment analysis, has resulted in an overall 44% reduction in inpatient admits. The ICT will emphasize the need to add both a psychiatrist, a therapist and a nutritionist with expertise in treating adolescents with eating disorders and who also provides telehealth services to augment the child's care team. Our network includes child and adolescent psychiatrists and 31 nutritionists who treat eating disorders. If necessary, we will complete SCAs and set up telehealth platforms to provide the necessary care. These specialists coordinate care with her pediatrician. To prevent relapse and facilitate the transition home, we make sure E.F. has a crisis plan in place and and established relationships with her outpatient providers.

Outpatient Behavioral Health Services

To facilitate access to a psychiatrist, we will either arrange transportation to the psychiatrist practicing 1.5 hours away or we will arrange a single case agreement (SCA) with a local psychiatrist, whichever the family prefers. If the family chooses to see the psychiatrist 1.5 hours away, we will offer a hybrid model in which E.F. meets face-to-face with the provider regularly and has telehealth visits in between face-to-face appointments. The psychiatrist will provide medication management. The ICT will recommend evidence-based therapies, such as CBT for E.F. and Family Treatment (FT) for her family. Our network includes four providers of CBT and 10 FT providers with expertise in eating disorders, and we are actively expanding access to different levels of care to treat eating disorders.

Physical Health Services

E.F.'s pediatrician will monitor her weight, laboratory results and medication(s). If needed, our CM will support her local pediatrician by facilitating peer consultations with eating disorder specialists using the new activated behavioral health consultation codes, and access to clinical practice guidelines, with E.F.'s pediatrician as the "hub" and the eating disorder specialists as the "spokes." This hub and spoke model allows us to retain the trusted relationship between E.F., her family and her pediatrician, while supporting the pediatrician with access to consultation with expert peers.

Resources and Infrastructure

Health Education

E.F.'s CM will provide education to the family on the chronic and behavioral health components of her eating disorder. Our member portal, *myuhc.com*, includes an Eating Disorder center with additional educational resources. We will refer the family to support groups, many of them virtual, offered by the National Eating Disorders Association and the National Association of Anorexia Nervosa and Associated Disorders. The CM will connect the family to the Sanvello app, once implemented, and show them how E.F. can use it for behavioral wellness support. In addition, E.F.'s CM will explore with E.F. potential extracurricular activities she enjoys and help coordination access to those activities.

Coordination with School and Community-based Organizations

With permission from E.F.'s parents, her CM will contact her school to collaborate on development and implementation of an Individual Education Plan. We recognize recovery is a long-term effort and will continue to check in with E.F. and her family monthly throughout her time in case management.

~~2.6.7.9~~ 2.6.7.7 The Proposer has an enrollee that is a 25-year-old man with a past medical history of sickle cell …

Advance Health Equity

Our approach to addressing the needs of this individual, who we will call E.G., will begin with acknowledging he believes he has been treated unfairly by the health care system and subject to discrimination. The unfortunate truth is that discrimination in our health system does exist and mistrust and perceived discrimination contribute to poor health outcomes. UnitedHealthcare is committed to helping develop a system that learns and does better moving forward and is establishing a health equity action team (HEAT) of leaders from across all functional departments that will be led by our Health Equity Administrator. With E.G., we will work to establish a relationship of trust, thoughtfully listen to understand his concerns, and include him in establishing and implementing a plan of care based upon his expressed goals and preferences.

We believe we would have identified E.G.'s medical needs earlier, through risk stratification or hotspotting, and provided case management. It is possible we were unable to find him or he didn't respond to our earlier efforts. We collaborate with CHWs, CBOs, and other community and faith-based organizations to conduct field-based outreach to locate individuals without telephone access or who are hard to reach. If we had been able to reach him, we would have listened to his concerns and tried to address them by providing him culturally concordant and culturally sensitive care, and a suite of tools and programs to help him appropriately access health care services. Another resource we use to help enrollees get non-emergency care in appropriate locations is our ED navigator who coordinates care and services for enrollees who have high ED utilization. In the following section, we describe other options for his care outside of the ED.

~~2.6.7.9.1~~ 2.6.7.7.1 How will the Proposer address this enrollee's needs?

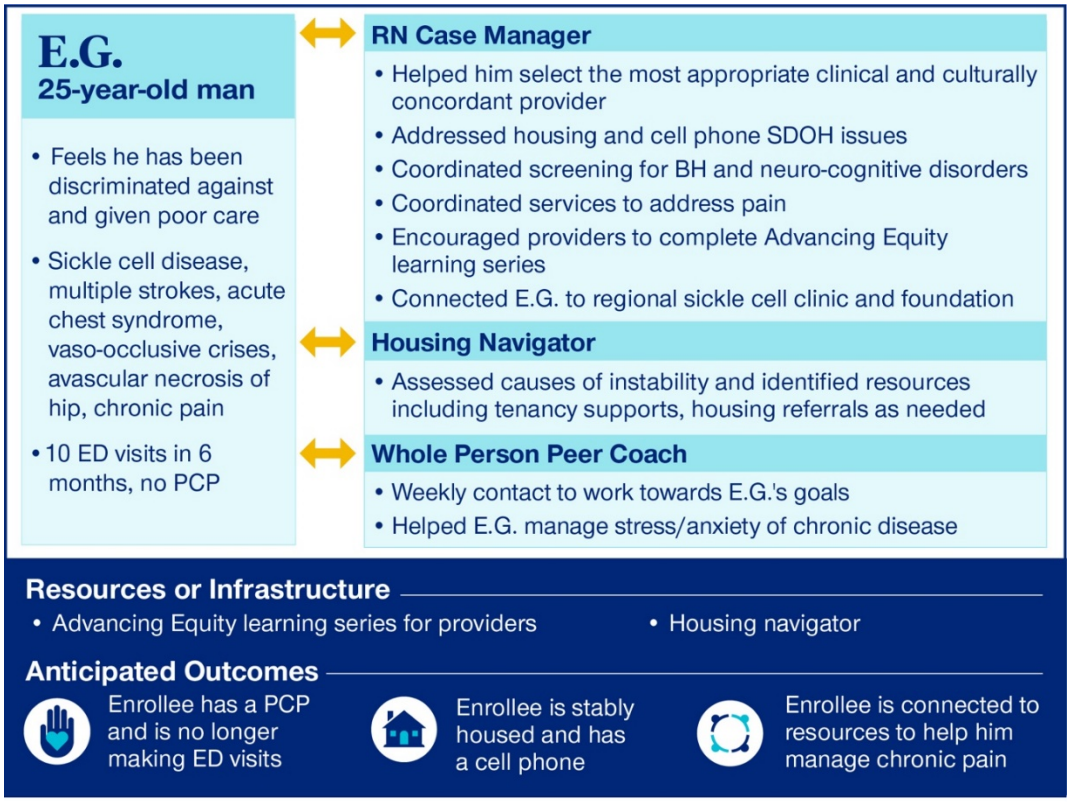

Figure 8. Case Management Strategy. We begin by acknowledging E.G. believes he has been treated unfairly by the health care system and subject to discrimination.

Addressing His Needs

Integrated Case Management

If E.G. is willing to participate in case management, we will assign him an RN case manager (CM) with expertise in complex conditions such as sickle cell, in Tier 3 case management. Our approach to care is a triad: 1) understand E.G.'s needs and demonstrate emphathy; 2) connect members to providers who deliver the best clinical care; 3) ensure E.G.'s care is culturally relevant and respectful of his experience and goals. We believe culturally concordant care has multiple facets that enhance connection, including shared language, race, background and life experience. The CM will pull together an ICT which includes our housing liaison and our medical directors. Our first priority is to use empathetic listening, cultural sensitivity and training in trauma-informed care to understand his past experiences with the health care system, while at the same time assessing existing gaps in his care to reduce acute exacerbations. We have achieved a reduction of 27% in ED utilization for enrollees like E.G. when comparing them six months pre and post enrollment in high risk case management. Using motivational interviewing techniques to re-engage in care, the CM will work with E.G. to select a PCP, a hematologist and other providers as needed. As E.G. selects his providers, the CM will listen carefully for his preferences and support him in his decision-making.

Screening and Assessment

Our RN CM will conduct an HNA, including a screening for SDOH needs. Working with the providers E.G. selected, the CM will coordinate a screening for depression, anxiety and SUD. The CM will work with the providers to coordinate with a neurologist to conduct a screen for neuro-cognitive disorders

(which are a risk among adults with sickle cell disease), and facilitate neurocognitive testing if recommended. All screenings and assessments will be conducted only with E.G.'s agreement.

Selecting a PCP

One of the first issues our RN CM will address through motivational interviewing with E.G. is to understand why he doesn't currently have a PCP and try to address any barriers he identifies that would prevent him from selecting a PCP. The CM will provide education on the role a PCP plays in making sure E.G. receives appropriate preventive care, including COVID-19 and other vaccines, and in coordinating his integrated care. The CM will assist E.G. in selecting the most appropriate PCP who is experienced with E.G.'s conditions, sensitive to E.G.'s concerns about past discrimination, and with whom E.G. is comfortable, including culturally relevant care should that be E.G.'s preference. Once E.G. selects a PCP, the CM will encourage the provider to complete the UnitedHealth Group Advancing Equity learning series, which offers CME and CEU credits on cultural competency, and offer provider training on motivational interviewing techniques to try to help keep E.G. engaged in his care.

Physical Health Services

Specialist Care for Sickle Cell

We will work with the PCP and E.G. to connect him to a hematologist and to the sickle cell clinic designated by LDH for his region.

Addressing His Chronic Pain

We will collaborate with the PCP to assess E.G.'s chronic pain and determine whether the PCP recommends referral to other resources, including behavioral health specialty providers with expertise in addressing the psychological aspects of chronic pain. If the PCP or a behavioral health specialty provider recommends biofeedback or CBT psychotherapy for pain and it meets medical necessity criteria, we will approve those services. If he lives near New Orleans, we will coordinate a referral to the palliative care program at University Medical Center, which includes a program for pain management in sickle cell disease. We will coordinate with his PCP to arrange a physical therapy evaluation and arrange for any needed durable medical equipment.

Social Determinants of Health

After screening and using motivational interviewing to identify any additional risk factors caused by SDOH beyond the need for a reliable mobile phone and stable housing, the CM incorporates interventions to address SDOH into E.G.'s individual plan of care. For example, if E.G. has transportation barriers that have prevented him from seeking care, we will offer NEMT to address those needs. We will address the two SDOH barriers we are aware of, arranging with our Assurance Wireless partner for him to receive a reliable smartphone. Our housing liaison will assess E.G.'s housing and identify the causes for the instability. She will identify possible resources including tenancy supports and resources and, if necessary, coordinate housing referrals and applications. If E.G. is interested in employment training, his CM will connect him to community-based resources for completing his GED or for vocational or college coursework. These resource referrals are monitored to ensure E.G. receives the supports he is seeking.

Behavioral Health Services

We discussed the possibility of referring to CBT or biofeedback for management of his chronic pain. In addition, if screening indicates E.G. has depression, anxiety, SUD or any other behavioral health

problem, we will add a BHA to his ICT who will help him understand the link between unmet behavioral health needs and poor medical outcomes. Our BHA will help E.G. with the selection of a behavioral health specialist with a triad of skills, sensitivity, empathy and cultural competence in responding to E.G.'s needs including his concerns about systemic racism. Since we have provided him with a smartphone, his BHA will help him acquire the Sanvello app, once implemented, and show him how to use it for behavioral wellness support. Our CM will continue to check in with E.G. at least monthly, with minimum quarterly in-person reassessments.

Enrollee Education

E.G.'s WHPC will visit him to provide coaching and other assistance. If he lives in Baton Rouge or New Orleans, he could choose to go to our member Wellness Centers in those cities and meet face-to-face with a CHW who will help him complete his HNA and find a PCP and other providers. These Wellness Centers also enable telehealth visits, if needed.

~~2.6.7.9.2~~ 2.6.7.7.2 What systems and policies will the Proposer have in place to promote health equity that would…

Promoting Health Equity

Cultural Competency

We will work with E.G. to assign him a CM who understands and can support his needs. We hire locally based CMs that reflect the communities we serve, who have experience working with diverse populations and receive specialized training in health equity, implicit bias, cultural responsiveness and trauma-informed care to provide person-centered, culturally relevant care. Recognizing some individuals may feel more comfortable, supported and satisfied with the care they receive from clinicians with whom they can relate, the CM will ask E.G. if he would like to be connected to a provider with relevant experience. If that is his preference, the CM will use our Provider Directory, which includes language and other special services or expertise offered by the provider and their staff (e.g., equity training) and a link to the provider's website (if provided) to suggest a qualified provider.

We will make sure his providers are aware of training we offer providers on health equity. We offer training for all providers in new provider onboarding and orientation webinars, site visits, town hall sessions, educational mailings and telephonic outreach. Topics include health equity and cultural competency. In 2021, we are partnering with the March of Dimes to promote awareness of implicit bias among providers.

We will assist him in filing a grievance related to the discrimination against him. Our quality management team will make sure grievances related to bias and discrimination will be handled in conjunction with the Health Equity Administrator for remediation. We encourage any enrollee who believes they were not treated fairly because of race, national origin, sex, age or disability to file a grievance with our Civil Rights Coordinator and with the U.S. Department of Health and Human Services. Finally, we will develop customized reporting and inquiry capabilities on multiple data elements including race and ethnicity. These customized reports will enable us to improve health equity and address barriers to care that contribute to disparities in health care outcomes.

Peer Support

To provide peer support, his care team will connect him to the sickle cell foundation for his region. Some of those foundations, such as the Northwest Louisiana Chapter of the Sickle Cell Disease

Association of America in Shreveport, offer support groups for those with sickle cell disease and their families.

If he is willing, his ICT will include a Whole Health Peer Coach (WHPC) who has experience and who has been trained in disease management. The WHPC will have weekly contact with E.G. via telephone or face-to-face, depending on his preferences, to work with him toward his recovery plan goals. As part of the ICT, the WHPC will attend rounds to help coordinate E.G.'s care.

Systems and Policies to Promote Health Equity

The following table highlights our continued commitment to adopt systems and policies promoting health equity. All of these programs will contribute to improving health equity for all enrollees as they raise awareness of implicit bias and cultural responsiveness among our staff and providers.

Key Commitments to Continue to Promote Health Equity in Louisiana
Empower Enrollees through Personalized, Culturally Competent Supports
• Expand community- and home-based support through use of **CHWs, peer supports, and doulas** • Require care team annual completion of specialized training in **health equity and implicit bias** • Enhance proactive, regular screening for social needs and **closed loop referral** to needed resources
Embed Health Equity in Fabric of Our Business and Metrics of Success
• Hire or promote local **HE Administrator** to lead a cross-functional h**ealth equity action team (HEAT)** and develop and implement our **Health Equity Plan** • Expand use of data analytics tools across all departments to design, implement, and evaluate **coordinated initiatives to address enrollee disparities** • Achieve **NCQA Distinction in Multicultural Health Care** by end of 2021
Evolve Care System to Increase Access and Drive Equitable Outcomes
• Invest in workforce development for a more ethnically and linguistically diverse provider network • Equip and offer provider education and support with training to address implicit bias • Deploy **value-based payment models** to incentivize improvements to reduce disparities in care
Engage Communities to Create Healthier, More Equitable Communities
• Use our Enrollee Advisory Committee, HESCC and community-integration models to engage stakeholders in shared decision making and co-creation of solutions • Invest in data-driven community capacity-building leveraging data from our SDOH Registry

Other systems and policies we have in place to promote health equity that would apply to E.G. include:

- **Recruiting, retaining and promoting representative personnel:** Nearly 45% of our Medicaid enrollees in Louisiana are people of color, and our health plan staff reflect those demographics, with 59% identifying as people of color. We will continue to recruit, retain and promote staff from the community with experience promoting health equity.
- **Delivering culturally appropriate services:** All our staff must complete "Through Their Eyes" cultural competency training to support national Culturally and Linguistically Appropriate Services (CLAS) standards and to meet the needs of enrollees, providers and business partners.

Please see our response to Section 2.6.5.1 for more information on our health equity goals.

2.6.7.8 The Proposer has an enrollee that is a 25-year-old woman who is pregnant and has opioid use disorder, …

We know from experience that this enrollee, whom we will refer to as E.H., will need immediate support for her complex needs. In 2020, we helped more than 400 expectant Louisiana enrollees with SUD, many of whom had comorbid behavioral health diagnoses. Because of this experience, we anticipate the challenges E.H. may face and will provide a diverse set of supports tailored to meet her and her baby's needs. Our Healthy First Steps (HFS) maternal and child case management program has proven effective for enrollees like her — our engaged enrollees have higher utilization of MAT than those who declined services. The wraparound support of HFS provides an integrated, whole-person care model when enhanced by partnerships with local providers and programs for enrollees. For example, recognizing the SUD crisis in Louisiana, UnitedHealthcare provided a $1.2 million grant to fund the Guiding Recovery and Creating Empowerment (GRACE) program through Woman's Hospital in Baton Rouge. This resource links enrollees to empathetic providers and recovery services to prevent women from avoiding prenatal care.

GRACE Program Partnership
GRACE offers specialized pregnancy case management for Medicaid enrollees with SUD or OUD. **Ninety percent of women in GRACE receive behavioral health services,** and the program has resulted in **babies born at a higher gestational ages and birth weights** relative to a comparison group.

2.6.7.8.1 What systems will the Proposer have in place to be able to identify this enrollee?

Identifying this Enrollee for Outreach

Achieve Operational Excellence

Systemic Analytics and Monitoring. We know identifying E.H. quickly is crucial to address her safety, housing and behavioral health needs. Her frequent ED visits would flag her for outreach via our ED Navigator program, the HealthView Analytics tool, or ADT feeds with Smart Alerts, which alert us in real time of ED visits and hospital registrations with a pregnancy code. We use weekly analyses to identify new pregnancies through resources such as claims data, inpatient admissions, laboratory results and use of pregnancy services. In addition, our Special Health Care Needs Report identifies enrollees based upon multiple factors indicating high utilization of services. If E.H. transferred to us from another health plan, we would potentially have learned of her needs through the transition of information.

Referrals. In addition to these identification efforts, enrollees may self-refer, or we receive direct referrals with enrollee consent, from providers, CBOs or family members. If E.H. visits an OB, they can send us a notification of pregnancy form (we incentivize providers who send these forms within a 15-day window). If E.H. uses our 24 hours a day, seven days a week SUD Helpline or NurseLine**,** a direct referral can be made to case management. The administrative lock-in program and pharmacy claims flag alerts — for example, concurrent use of benzodiazepines and opioids, or opioids and prenatal vitamins would flag her for referral for outreach. We also diligently partner with CBOs to increase awareness of our services, which leads to referrals. For example, if she engages one of our partners, Healthcare for the Homeless, they will refer E.H. to HFS and to our housing liaison, who has an established relationship with this CBO.

2.6.7.8.2 What specific steps will the Proposer take to address this enrollee's needs? The Proposer should list …

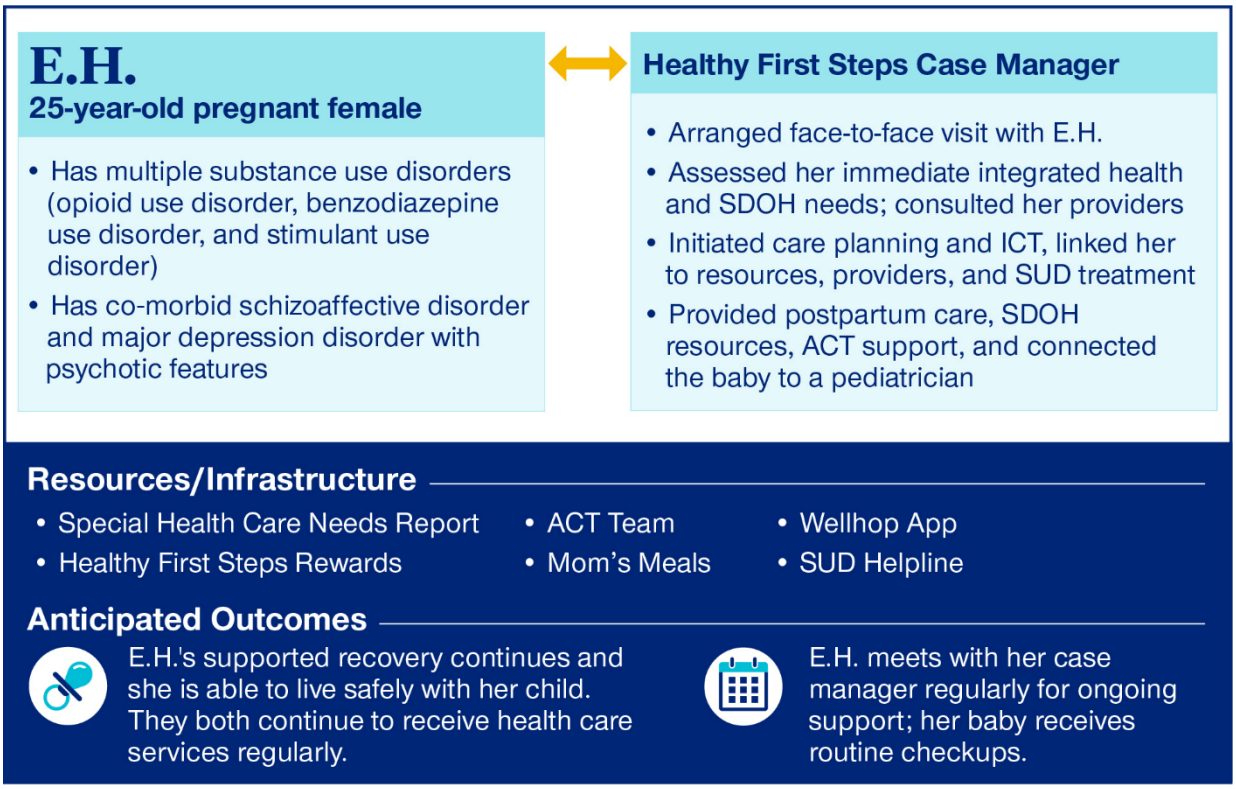

Figure 9. The HFS CM will work with E.H. and her care team, using specific steps to address her complex needs.

Steps Taken to Address E.H.'s Needs

Once identified, E.H. will be assigned a HFS RN CM, who is trained in assisting both pregnant women with complex needs and their babies. E.H.'s CM will take the lead role and be her key point of contact. The CM will meet E.H., establish rapport, build trust with empathy, engage her in care, and work with other care team members to triage her most immediate needs.

Meet E.H.: Engagement in Care Management

Contacting E.H. may be challenging — the CM will make at least six telephonic outreach attempts and if unsuccessful, a field-based CHW can conduct a home visit. Once outreach is successful, we will explain the role of her MCO in her health care and the services we can provide, such as NEMT for provider visits. The CM will conduct a HFS clinical assessment with E.H. She may distrust the health care system, so it is critical that we express to her that we are here to partner with her and support her goals. If necessary, the CM may get help from our staff peer support specialist, whose own lived experience may encourage E.H. to feel more comfortable engaging in shared decision-making. To address E.H.'s significant behavioral health needs, the HFS CM would collaborate with a behavioral health advocate (BHA), who would assess E.H.'s needs and readiness for change. The CM would enlist a housing liaison to assist with a housing strategy. If E.H. isn't ready for case management, we will tell her about resources she can engage and explain how she can reach us when she decides she is ready. After our first invitation, we will try again to engage her in case management at a later date.

E.H. is a candidate for the most intensive Tier 3 high-risk case management level, which will provide an in-person assessment; in-person meetings held at least monthly at her preferred locale; quarterly

in-person reassessments; telephonic or video access to her HFS CM as needed; and an interdisciplinary IPOC within 30 days of enrollment in case management. Her CM will offer **UnitedHealthcare Care Support** to enable virtual face-to-face contact with her, wherever she is.

Address Immediate Housing, Behavioral and Medical Safety Needs

We understand E.H. may be hesitant to engage with us, so the care team will work to build rapport with her so we can help her feel safe and comfortable sharing her needs with us. The CM will partner with E.H. in resolving her most urgent care gaps in order of immediacy and importance to her. If she seems to be in acute mental health crisis, we will immediately connect her with emergency services. If she is in Orleans parish, we can call Acadian Ambulance to her location for an immediate assessment and connection to a telehealth visit, so a provider can determine whether she needs to be seen in the ED. Once her crisis is stabilized, we will move through the next steps of her care.

If E.H. does not require immediate medical intervention, we will begin doing several activities simultaneously: counseling her about the importance of having ready access to naloxone and facilitating a prescription, reconnecting her to her behavioral health provider or establishing her with a new one, establishing care with an OB provider, and ensuring she has a safe place to live. This is where our trauma-informed training, empathetic listening, strong interpersonal skills, and knowledge of our community will do the heavy lifting of building trust and demonstrating real support for E.H. We have a wealth of provider knowledge and can seek specific strengths in her providers, such as an OB who can also prescribe MAT; an OB that delivers at Woman's Hospital, where she can benefit from the GRACE program; or a behavioral health provider skilled in treating her schizoaffective disorder, depression, and SUD issues who also offers telehealth visits.

We will work to remediate risks and meet her SDOH needs, which is crucial to her ability to successfully adhere to her IPOC. Our local, well-connected housing liaison will evaluate her options for emergency and low barrier shelters, such as New Orleans Women and Children's Shelter, Reality House or Catholic Charities. We will ensure she has access to nutritious food and can arrange for Mom's Meals to be delivered once she is housed. We will provide her with a smartphone with adequate data for ongoing outreach from her CM, who will help her apply for services like WIC, SSI, and Supplemental Nutrition Assistance Program (SNAP), as applicable.

Connect and Create an Individual Plan of Care

With initial appointments made or already attended, the CM can actively work with E.H. on her person-centered IPOC. Our IPOC will identify social supports she may have and where she experiences gaps. For example, she may have benefits she was unaware were available to her. Once we establish a team, with her permission, we will create an ICT comprising her HFS CM, a BHA, medical and pharmacy directors, her providers, peer support and housing liaisons, and family or natural supports she identifies. The ICT will facilitate integrated care coordination, service authorization, utilization management, and promote collaboration with her. E.H.'s case will be discussed in integrated Perinatal Continuum rounds, which include our behavioral health medical director and our medical director, who is an obstetrician.

Partnering with Providers. We will be flexible, pivoting to support E.H.'s care plan as it evolves by expediting providers' ability to get her the resources she needs, such as assisting with prior authorizations or specialist referrals. Through this care coordination, the CM will support the SUD treatment recommended for E.H. by her providers, because we recognize an enrollee with this many

challenges needs the encouragement of getting the care she needs without delays. We can also offer education to the OB provider through means such as the Substance Use in Pregnancy toolkit.

Reducing NAS in the NICU
Our initiatives to educate providers on prescribing opioids to pregnant women and enhanced screening and referrals to treatment resulted in **a 27% reduction in incidence of Neonatal Abstinence Syndrome (NAS) among our NICU population** in Louisiana enrollees from 2019 to 2020.

Addressing SUD During Pregnancy. To support providers' recommendations and E.H.'s choices, we have providers at all levels of care capable of treating expectant mothers with SUD. For example, we partner with Eleanor Health, which offers comprehensive treatment for opioid and other substance use disorders, including MAT, and connection to community-based resources for adults. They offer both in-person and virtual services to pregnant women. Other options include Red River Healthcare, the GRACE Program; Odyssey House; the Louisiana Mental Health Perinatal Partnership; and ACER. Tele-MAT therapy with a Louisiana-based provider is available through Bright Heart Health. In addition, our Wellness Centers offer telehealth consultation rooms where she could connect to a provider treating her SUD.

Perinatal Support. In addition to CM visits, we can work with **Birthmark Doula Collective** if she is in the New Orleans area for additional in-person supports, such as birth coaching, and postpartum support. We provide access to Wellhop, an app that provides educational support-by allowing E.H. to join live group discussions with other expectant and postpartum enrollees. The CM will begin to ask E.H. about her postpartum plans and family planning options during her pregnancy. They will build E.H.'s goals into her IPOC before delivery, including ways to arrange for her choices with her providers. We will prepare her for the possibility her baby may need NICU care at delivery. Because we are sensitive to the fact that many pregnant individuals dealing with SUD are concerned DCFS may become involved once she delivers, we will partner with her to achieve her health goals in preparation for delivery by empowering her with the tools she needs.

After Delivery: Ongoing Support for Mom-baby Dyad in the Postpartum Period

E.H.'s CM has many tools available to provide ongoing resources and support to E.H. and her baby, in response to E.H.'s goals and needs for support.

Postpartum Care	Recognizing the postpartum period carries a high risk of SUD relapse or depression, our CM will encourage E.H. to follow up with her OB and behavioral health providers promptly. Her care team will routinely assess her for postpartum depression. The CM will update her IPOC, incorporating E.H.'s new goals for herself and her infant. Receiving behavioral health support and help with developing a PCP medical home will empower E.H. to maintain community tenure.
Parenting Support	If E.H.'s child needs NICU treatment, we will connect her to resources such as Saul's Light, which provides emotional support and advocacy. We can connect her to resources such as Triple P Positive Parenting Program, and family support classes, such as those at Family Road of Greater Baton Rouge. She may desire parenting education or home visiting support through programs such as Healthy Start. If she is cleared by her providers to breastfeed, we can offer lactation support. We want to give E.H. hope and encouragement at every turn.
SDOH Support	If E.H. needs a change in her housing plan, our housing liaison can help her apply for new arrangements. If she qualifies for permanent supportive housing (PSH), we will link her with a mental health rehabilitation agency that specializes in PSH tenancy supports. We can arrange post-discharge meals for two weeks (or longer) through our partnership with Mom's

	Meals. We can connect her to CBOs, such as Crescent City Family Services, for resources including diapers and car seats, or food pantries, such as Common Ground in Shreveport. We will continue to provide NEMT to support her ability to get care.
Mental Health Resources and Long-term SUD Recovery	We will help E.H. to visit her behavioral health provider and make her aware of emergency options in case she becomes overwhelmed. If she is in the New Orleans area, her CM or our NurseLine staff can directly refer her to the Acadian Ambulance Treat in Place referral service, which can assess her immediately in person. Our SUD Helpline offers E.H. immediate, anonymous, and non-judgmental support from substance use recovery advocates. We can provide NEMT to Narcotics Anonymous and Self-Management and Recovery Training (SMART) meetings. If she enters inpatient SUD treatment, an ACT team in her area will be an available resource. Alternatively, Project Mosaic provides advocacy for individuals with serious mental illness or SUD. Its team of field-based peer support specialists and BHAs actively engages individuals to provide person-centered care and crisis support. This resource is available in Baton Rouge and will be available in New Orleans later this year. Her CM will work with E.H. to have a plan in place for her childcare if she chooses to receive residential SUD treatment after delivery.
Continuing Peer Support	Our Whole Health Peer Coach (WHPC) program provides WHPCs who address enrollees' medical and behavioral health needs with weekly phone calls and face-to-face meetings. The WHPC would review and update E.H.'s IPOC progress with her, help to coordinate care with her care team during rounds, and provide recovery and resiliency support.
Medication Adherence Support	Based upon E.H.'s diagnoses, she would qualify for medication adherence support. Regardless of where she fills her prescriptions, a Genoa pharmacy team member would monitor for early indications for non-adherence, conduct outreach, and help her overcome barriers inhibiting her ability to adhere to treatment.

2.6.7.8.3 What steps will the Proposer take, both pre- and postpartum, to ensure that the newborn is linked to a …

Connecting the E.H. with a Pediatrician for Her Child

HFS Rewards Lead to Higher Value Care
In Louisiana, HFS Rewards participants attended 14.3% more physician visits, increased their prescription fills by 11.1% and have a 5.7% lower rate of ED utilization, on average.

During her pregnancy, E.H.'s HFS CM will work with her to choose a pediatrician, providing her with a list of accessible pediatricians in her area and assisting with scheduling visits. We will work to find a local pediatrician who is empathetic to E.H.'s situation. We will encourage and assist E.H. to meet the pediatrician and their staff prior to delivery. We will offer to coordinate transportation to all medical appointments for E.H. and her infant through our NEMT benefit. E.H. will have access to our mobile-friendly HFS Rewards Program, which will encourage her to make and keep doctor's appointments, including well-visits, through the child's first 15 months of life, by providing rewards such as gift cards and diaper bags. The HFS website provides education, resources, and appointment reminders through email and text messages. During the postpartum period, her CM will continue to encourage pediatrician visits for E.H.'s newborn during outreach calls until completion of the first newborn appointment. These benefits will be included in the E.H.'s IPOC goals and will be a part of her follow-up care. Our HFS program has led to 14.3% more physician visits, 5.7% fewer ED visits and an 11.1% increase in prescription fills.

~~2.6.7.11~~ 2.6.7.9 The Proposer has an enrollee that is a 57-year-old woman who has a history of poorly controlled …

Elevate Integrated Care

About 27% of adults in the United States suffer from multiple chronic health conditions (National Health Interview Survey, 2018). Adults with multiple chronic health conditions have worse health-related quality of life and higher health costs. In Louisiana, 32% of our enrollees with co-occurring conditions drive 62% of our ED utilization. We will take an integrated, person-centered approach to understanding the reasons why this individual, who we will call E.I., has been accessing acute care this way. We will assure she has access to services to address her identified needs.

We will begin by working with E.I to assign her a CM who can support her needs. We hire locally based CMs who reflect the communities we serve, and have experience working with diverse populations and receive specialized training to provide person-centered, culturally concordant care. Recognizing some individuals may feel more comfortable and satisfied with care they receive from clinicians with whom they can relate, the CM will work with E.I. to find providers relevant to her. Working in an integrated, interdisciplinary team approach to her care, the CM will use their training in motivational interviewing, person-centered care planning and cultural competency to engage E.I. in her care.

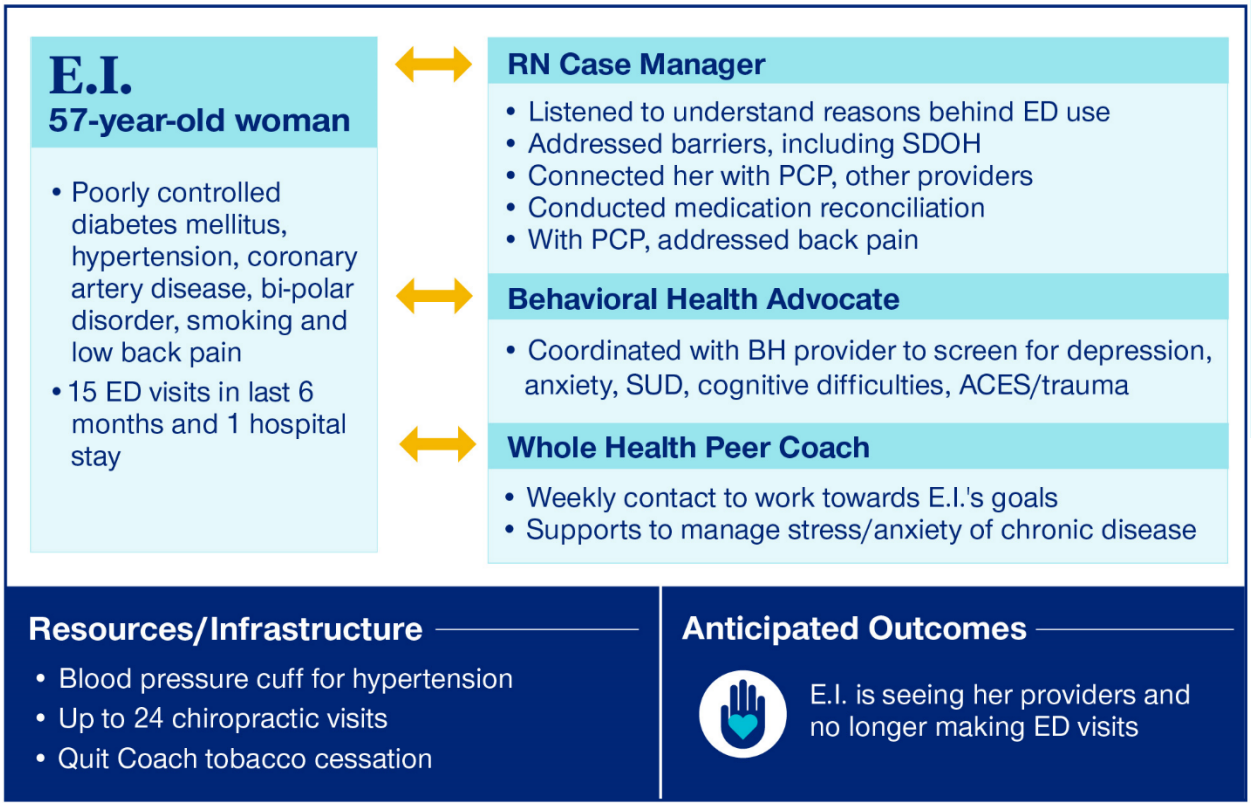

Figure 10. Case Management Strategy. Our CM will use their training in motivational interviewing, person-centered care planning and cultural competency to engage E.I. in her care.

We believe we would have identified E.I.'s inappropriate ED use earlier through risk stratification or our Hotspotting tool. Perhaps she recently moved, or she didn't respond to outreach. We collaborate with CHWs, CBOs, and community and faith-based organizations to conduct field-based outreach to locate individuals who are hard to reach. If we had been able to reach her, we would

have offered her tools to help her access health care services, including case management for her health care needs. We have an ED Navigator program, where a CM monitors ADT feeds to identify individuals using the ED inappropriately. Our case management program has reduced ED visit costs before engagement by 26% after enrollment in case management. In the following section, we describe other programs to provide care outside of the ED.

~~2.6.7.11.1~~ 2.6.7.9.1 What process would the Proposer use to understand the reasons behind this enrollee's use of …

Process to Understand Reasons Behind Use of Acute Care

Once we are able to engage E.I, will first ***listen*** to her. The CM will explore whether E.I. is currently connected to care and a PCP. The CM will help E.I. connect with an appropriate PCP or, if she has one, coordinate with the PCP as they use motivational interviewing techniques to ask E.I. about her history seeking health care and her health goals. With permission, the CM will interview family, friends or other supports to identify pertinent history.

With E.I.'s permission, our RN CM will conduct an HNA and comprehensive assessment, screening for medical, behavioral and SDOH needs. If E.I. has a behavioral health provider who manages her bipolar disorder, the CM will work with the BHA and behavioral health provider to coordinate screening for additional behavioral health needs such as depression or anxiety, SUD, cognitive difficulties, ACEs or trauma. If E.I. does not yet have a behavioral health provider, the BHA and CM will work with E.I.'s chosen PCP to screen while they work with E.I. to select a behavioral health provider. They will explore whether E.I. is seeking acute care for social services or emotional needs or if there are other underlying issues to address.

If E.I. is willing, **we will provide a Whole Health Peer Coach (WHPC)** with experience recovering from physical and mental health conditions and who has been trained in disease management.

If E.I. agrees to engage with a peer coach, the coach will work with her interdisciplinary care team (ICT) in understanding the patterns of her ED use. Potential reasons include:

- SDOH needs such as transportation or family and work obligations
- She may live in a food desert or not be able to follow dietary recommendations; her neighborhood may have no green spaces or there may be violence that prevents her from being active.
- She may have a history of ACEs that contribute to the onset and perpetuation of chronic relapsing conditions.
- She may be a member of a minority community that has experienced institutionalized racism and bias that affects her engagement with health care.
- There may be gaps in access to specialty care. The CM's knowledge of their local community, including care gaps, and local cultural hesitancy around seeking health care will inform their understanding of the reasons behind E.I.'s use of acute care services.

~~2.6.7.11.2~~ 2.6.7.9.2 How would the Proposer address the enrollee's identified needs? Give specific examples of …

Addressing Needs through Coverage of Medically Necessary Services

Once we have identified E.I. as having multiple chronic medical and behavioral health needs, we will assign her to Tier 3 case management, led by a RN CM who will bring together an ICT if she is willing to accept. The ICT will include our ED navigator, our medical directors, the RN care manager, a co-located BHA, E.I. and any family or friends she wants to include. Our CM will serve as her primary contact.

Tuck-in Program

We worked with targeted providers to adapt an evidence-based "Tuck-in" program.

- Through a provider-led telephonic care management model, individuals receive 1:1 weekly outreach from a case manager at their PCP office to check in on vitals (e.g., blood pressure), medication adherence, diet and exercise.
- The provider makes sure individuals are connected to needed services and supports, including covered blood pressure cuffs.

Managing Physical Health Services

E.I.'s PCP will coordinate care with her specialty care providers to address her medical needs, and conduct her routine care, including preventive care, COVID-19 vaccine and flu shots. Our RN CM will work with the PCP to verify E.I. has a blood pressure cuff for use at home. This approach could help E.I. to feel better connected to care and allows her providers to be able to reach her in a timely manner, rather than waiting for a concern to rise to the level of ED need.

Back Pain

To address E.I.'s back pain, the RN CM will work with her PCP to arrange a physical medicine and rehabilitation consult with a physiatrist for a prescription for physical therapy if appropriate. The CM will encourage E.I. to access free mindfulness exercises on our Sanvello app and work with the PCP to evaluate if any non-narcotic pain medications should be prescribed. If E.I. and her PCP believe it will help, the CM will help access our value-added benefit of up to 24 visits per year of chiropractic services and biofeedback services.

Smoking Cessation

In addition to referring E.I. to services she may be eligible for through Well Ahead and the Smoking Cessation Trust, her care team will help her access five program sessions, via modalities including telephone or group video, with a Quit Coach through our Quit For Life® tobacco cessation program, offered as a value-added benefit.

Managing Behavioral Health Services

We will include E.I.'s behavioral health providers and WPHC on her ICT and engage her to identify her preferences and have that guide development of her individual plan of care. If she is agreeable, the WPHC will work with her to create her Wellness Recovery Action Plan, including a crisis plan. The WPHC will link her to community-based or online support groups, such as the Depression and Bipolar Support Alliance (DBSA).Optimally, if her screening reveals a substance use disorder (SUD) her individual plan of care (IPOC) will include treatment from an outpatient provider who specializes in co-occurring mental health and SUD. This provider will coordinate services with her PCP after obtaining appropriate permission from E.I. to release information, including sensitive health information on any substance use disorder.

Addressing Social Issues

Once the CM has conducted an SDOH screen and used motivational interviewing to determine the reasons behind E.I.'s use of acute care, the CM will incorporate into the individual plan of care measures to address social needs which may be driving the high utilization. For example, if E.I. lacks a smartphone, which can be used to schedule and access information on the member portal, the CM will work with our Assurance Wireless partner to get her a reliable smartphone. The CM will continue to engage E.I. through monthly check-ins, identifying changes to her situation and arranging services for her accordingly, leveraging our SDOH resource and referral platform.

Common Medical, Psychosocial and Behavioral and Social Issues among Medicaid Enrollees

We proactively identify and improve population health outcomes and advance health equity for all in Louisiana using the Institute for Healthcare Improvement (IHI) Model for Improvement. We use data analyses, including stakeholder engagement, to understand the key drivers of health. Common medical, psychosocial and behavioral and social issues among our Medicaid enrollees include:

Medical	Psychosocial and Behavioral	Social
Hypertension	Opioid use disorder	Transportation
Obesity (adult and child)	ADHD	Food insecurity
Diabetes mellitus	Autistic disorder	Housing
Heart disease	Major depressive disorder	

~~2.6.7.11.3~~ 2.6.7.9.3 How would the Proposer manage this enrollee in the community to increase patient…

Managing Health in the Community

If we first encounter E.I. while she is still hospitalized, our health care transitions team will have the first contact with her. This team will work with the hospital discharge staff to plan her discharge and support her needs. Our ED Navigator might also connect with her during an ED visit, reaching out to intervene in her pattern of ED use. After discharge, E.I.'s PCP will coordinate with her ICT to manage her care, including endocrinology, cardiology, metabolic monitoring and women's health care.

If the Individual Has No Usual Source of Care

If the CM determines E.I. does not have a PCP, the CM will work with her to identify a PCP who matches her preferences. One

Alternatives to ED Use

In addition to encouraging E.I. to connect with her PCP or care manager first, or use our NurseLine or behavioral health call center, available 24 hours a day, seven days a week, we offer innovative alternatives to ED use:

- **Acadian Ambulance:** If she lives in a parish served by Acadian Ambulance, we can initiate a referral for their field-based providers to work with her in her home. We are the only MCO currently making direct referrals to Acadian. They will meet with her in her home, assess her, do a telehealth physician consult and take her to the ED if necessary. Afterwards, they will share any results with her treating PCP.
- **Ready Responders:** We can initiate a referral for this network of trained EMTs, paramedics and nurses to visit E.I. They will connect with her via a telehealth consult to address her conditions, monitor prescription adherence, and evaluate her risk factors for ED use. They will counsel her on the appropriate settings for health care and encourage her to use her PCP.

option the PCP will explore with E.I., depending on her geographic location, is an FQHC, where care for her medical and behavioral health needs can be fully integrated.

Medication Reconciliation and Medication Management

In addition to the medication reconciliation done while she was inpatient, E.I.'s CM will use the Rx Claims platform to reconcile her outpatient medications. If she is not filling her medications for her bipolar disorder, her CM may connect her to a CMHC with a designated Genoa pharmacy to manage her medications.

Supporting Adherence to Treatment Plans and Recommendations

Education to Increase Patient Engagement and Adherence

During the care team's contact with E.I., they will seek to understand supports she has in her community. With those supports, her care team will provide education to lead her to self-advocacy. We will encourage her providers to use shared decision making to increase her engagement and the whole person peer support coach can coach her in shared decision-making. If she is in New Orleans or Baton Rouge, her team will refer her to the Depression and Bipolar Support Alliance.

Nutrition

To help E.I. manage her chronic conditions, if she is readmitted in the future, her CM will arrange for her to receive Mom's Meals that meet dietary restrictions. She would receive two meals a day of her choosing for seven days after her discharge.

If she is receiving care at an FQHC or CMHC, her providers could receive nutrition education we are planning to make available to providers through the Tulane Culinary Division.

Community-based Resources

With her PCP, the CM will refer E.I. to a nearby facility offering Diabetes Self-Management Education and Support (DSMES) through LDH's Well Ahead. She can get up to 12 hours of training. Participating facilities offer services like cooking demonstrations, recipe substitution ideas and meal planning; grocery store tours with registered dieticians and exercise prescriptions.

2.6.8 Network Management [10-page limit]

2.6.8.1 The Proposer should demonstrate how it will ensure timely access to culturally competent primary and …

We support providers to make sure their experience with UnitedHealthcare is positive and they have the tools to further health outcomes of enrollees.

Our Louisiana Medicaid network of 25,328 providers serve more than 500,000 Louisiana enrollees. Throughout our nine-year tenure in the Louisiana community, we have maintained longstanding relationships with independent clinicians, physician groups, behavioral health providers, hospitals, FQHCs and RHCs, ancillary, and other providers essential to enrollee care. As evidenced by our excellent quality scores, extensive network, and intentional efforts to facilitate access to care, we are successful in making sure enrollees have access to Louisiana's practicing providers and culturally competent services they need.

Unique Provider Counts		
Year	2015	2021
PCP*	3,052	3,220
Specialist**	9,240	13,103
Behavioral Health	7,268	7,814
Hospitals	134	147
Ancillary	658	1,044
Total	20,352	25,328
*Includes FQHCs and RHCs **Includes OB/GYN and extenders		

Louisiana has medically underserved areas and populations, and we understand the challenges that creates for enrollees' access to care. We address these needs by supporting access to providers who offer innovative solutions such as expanded hours of operation and offering telehealth with local providers. We also acknowledge that new network adequacy requirements related to utilization are focused on confirming access for Louisiana enrollees. We proactively make sure our actions are congruent with the State's expectations by partnering with our existing provider network to offer innovative and targeted health initiatives in addition to developing a plan to fill gaps created by new network standards as outlined in Section 2.6.8.2.1. Following is an example of a partnered initiative that identified and addressed enrollee needs in a culturally sensitive manner.

> "Working with United Healthcare during this COVID pandemic has been a very fulfilling partnership. We have collaborated on over 20 community vaccine events, specifically focused on increasing education and access for the Spanish speaking community. We look forward to furthering this partnership with an educational series where a medical provider answers community questions to help get people engaged in medical care.. The social media and community outreach that they do helps link people to care and we are grateful to continue to work together to increase community knowledge of healthcare services and Latinx engagement in healthcare."
>
> - Katie Conner, MPH, COVID-19 Vaccine Manager at CrescentCare

Strategies to promote LDH's goals of utilizing providers who are accepting new Medicaid patients or are regularly serving Medicaid patients in their offices or practices include:

- **Value-based Payment Programs** with requirements and incentives for open panels, accepting new Medicaid patients and extended hours in support of timely access to care
- **Recruitment, development and maintaining a network** reflective of the communities where our members live and recognizing that a culturally competent network goes beyond race,

ethnicity, and language to include supports for addressing social determinants of health like food insecurity, housing, transportation, community, and educational resources. We are launching our **SDOH Pilot program,** more fully described in Section 2.6.12, in fall 2021.

- **Cultural Competency** training is promoted, encouraged, and made available to our providers. This training is easily accessible to our providers and their staff through our provider portal. Topics include social inequities of health, cardiovascular risk and resilience in the African American community, caring for the LBGTQ community, behavioral health screening and treatment in primary care and trauma-informed care. In 2022, we are launching an incentive program for practices who complete Cultural Competency training currently available on our provider website.

NCQA Recognition
UnitedHealthcare has Louisiana's highest overall NCQA quality rating and three major component ratings — Consumer Satisfaction, Prevention, and Treatment — among the five Medicaid MCOs during NCQA's two most recent rating years.

- **Informed Member PCP Assignment.** Enrollees are first assigned to their provider of choice. If the enrollee has not selected a PCP, we use our Provider Recommendation Engine (PRE) tool to connect members to providers who have shown their engagement and demonstrated their quality and cost efficiency. Using PRE supports LDH's goals of using engaged providers who are accepting new Medicaid patients.

In addition to these strategies, our *Provider Directory* includes required data elements, including whether providers are accepting new Medicaid patients, hours of operation, gender, languages, and areas of expertise to aid our members in researching providers.

Our network participation agreements require providers to comply with appointment and wait-time access standards to promote timely access to care. We educate providers about these standards and cultural competency in our provider orientation town hall meetings, ongoing provider group meetings, one-on-one provider office training sessions, the *Care Provider Manual*, our provider newsletter *Practice Matters* and network bulletin updates, and educational materials on our provider portal. As part of their contract, providers agree to make covered services available and offer hours no less than the hours of operation offered to commercial and employer group members.

Timely access to care is essential for our enrollees and their families. We monitor appointment availability as described in 2.6.8.2.5 and develop performance improvement plans accordingly.

2.6.8.2 Specifically, the proposal should include:

2.6.8.2.1 Work plan that includes strategies and timeline to build, scale up, or maintain its provider network to …

We acknowledge the comprehensive standards the State has presented in Attachment F, Provider Network Standards, and the impact to our network. We have established a workplan to meet adequacy prior to readiness review. In accordance with the new provision, we will only consider physical health providers who have submitted at least 25 claims in an office setting within the prior six calendar months; behavioral health providers who have submitted at least 25 claims within the prior six calendar months; or any providers who were credentialed within the prior six calendar months, regardless of claims submissions. These new criteria eliminate nearly 2,450 unique physical health and 742 behavioral health providers from consideration. An aggressive strategy is being implemented to address these gaps and meet standards in Attachment F.

Work Plan to Scale Up Network Adequacy in Accordance with the Model Contract Requirements
Bifurcated approach focusing on:
- Contracts with additional providers available in the area
- Address providers contracted and not seeing enrollees in their office

Project	Actions	Timeline
Statewide provider recruitment campaign targeting providers identified to resolve gaps described in 2.6.8.2.2 and a broad campaign directed to non-network providers across the state.	• Identify providers for targeted campaign • Initiate recruitment contracting* and onboarding process	Q3 2021 Q3 2021 through Q1 2022

Address provider engagement by outreaching to contracted providers with self-reported closed panels or identified through feedback.
Outreach to providers with less than 25 office setting claims and behavioral health providers with less than 25 claims submitted during Q1 and Q2 of 2021.
The goal of this outreach is securing commitment to accept Medicaid patients. With this campaign we will inform targeted providers of opportunities available through our Value-based Payment programs more fully described in 2.6.12. These programs support providers by providing incentives for improving care and require open panels.
	• Identify providers with closed panels and/or not meeting claim threshold
	• Evaluate providers for potential collaboration using Value-based Payment programs, such as: PCMH, OB gap closure, SDOH Incentive Program, Specialist Incentives**
	• Strategic campaign to address issues such as providers near threshold vs providers with no activity with goal of:
	  • Securing affirmation from providers of their commitment to treat Medicaid population
	  • Verifying accurate demographic and practice information
	• Updating records for accurate directory information and reporting, including suppression of providers that indicate closed panels
		Q3 2021
		
		Q4 2021 through Q1 2022

Support engaged providers in their efforts to close care gaps through office visits. This will include identifying providers with hard-to-reach patients and assessing patterns of inappropriate ED use with focused efforts to encourage enrollees to seek care in their provider's office. Actions will include providing education on NEMT services.	• Identify providers with low volume of office visit claims and/or utilization history treating enrollees with identified care gaps, or PCPs with assigned members having identified gaps in care • Strategic office visit campaign to encourage care gap closure; prevention of providers currently meeting the claims threshold from becoming uncompliant	Q3 2021 Q4 2021 through Q1 of 2022

Evaluating Reimbursement If a provider requires reimbursement rates above the proposed fee schedule, we develop flexible contracts that provide additional reimbursement tied to value-based care to drive improved quality, health outcomes and lower costs. Examples include foundational payments tied to evidence-based integrated models (e.g., collaborative care model), pay for performance, pay for quality gap closure and shared savings.

****Launching our Specialist Incentive Programs Q4 2021*** To help improve access to specialists, we will reward providers for closing gaps in care in the following specialties: orthopedics, neurology, neurosurgery, pulmonology, endocrinology, rheumatology, ear nose and throat, gastroenterology, pediatric surgery or cardiology. We are targeting 15 specialist providers to engage in this program by Dec. 31, 2021.

2.6.8.2.2 Identification of network gaps (distance standards, after-hours clinic availability, closed panels, etc.);

We measured our network (as of July 2021) according to the standards in Attachment F. The results are listed in the following table. For our analysis we eliminated from consideration unique providers at NPI level, with closed panels, not actively serving enrollees, as evidenced by not meeting the minimum claim threshold described in Attachment F and stated above in 2.6.8.2.1. We are addressing all variances to LDH's standards as described further in 2.6.8.2.1, 2.6.8.2.3 and 2.6.8.2.6.

Provider Type	Meeting Adequacy	Existing Gaps
Adult PCP	39 parishes meet 100% access within the distance standard	In the 25 parishes with gaps, 97.8% of enrollees have access within the standard.
Pediatric PCP	43 parishes meet 100% access within the distance standard	In the 21 parishes with gaps, 97.2% of enrollees have access within the standard.
OB/GYN	22 parishes meet 100% access within the distance standard	In the 42 parishes with gaps, 92.2% of enrollees have access within the standard.
Allergy/ Immunology	45 parishes meet 100% access within the distance standard	In the 19 parishes with gaps, 48.3% of enrollees have access within the standard. Minimum Provider to Enrollee Ratio not met in Region 6.
Dermatology	46 parishes meet 100% access within the distance standard	In the 18 parishes with gaps, 45.2% of enrollees have access within the standard. Minimum Provider to Enrollee Ratio not met in Region 5.
Endocrinology	45 parishes meet 100% access within the distance standard	In the 19 parishes with gaps, 67.3% of enrollees have access within the standard. Minimum Provider to Enrollee Ratio not met in Regions 4, 5, and 6.
Gastroenterology	62 parishes meet 100% access within the distance standard	In the 2 parishes with gaps, 94.1% of enrollees have access within the standard.
Hematology/ Oncology	57 parishes meet 100% access within the distance standard	In the 7 parishes with gaps, 77.8% of enrollees have access within the standard.
Nephrology	63 parishes meet 100% access within the distance standard	In the parish with a gap (Plaquemines), 12.7% of enrollees have access within the standard.
Neurology	60 parishes meet 100% access within the distance standard	In the 4 parishes with gaps, 94.1% of enrollees have access within the standard.
Ophthalmology	63 parishes meet 100% access within the distance standard	In the parish with a gap (Plaquemines), 92.3% of enrollees have access within the standard.
Otolaryngology	62 parishes meet 100% access within the distance standard	In the 2 parishes with gaps, 97.0% of enrollees have access within the standard.
Urology	59 parishes meet 100% access within the distance standard	In the 5 parishes with gaps, 74.6% of enrollees have access within the standard.
Psychiatrists	28 parishes meet 100% access within the distance standard	In the 36 parishes with gaps, 92.5% of enrollees have access within the standard.
Licensed Mental Health Specialists	23 parishes meet 100% access within the distance standard	In the 41 parishes with gaps, 97.4% of enrollees have access within the standard.
Behavioral Health Rehabilitation Services	40 parishes meet 100% access within the distance standard	In the 24 parishes with gaps, 89.3% of enrollees have access within the standard.

Provider Type	Meeting Adequacy	Existing Gaps
Cardiology	62 parishes meet 100% access within the distance standard	In the 2 parishes with gaps, 97.4% have access within the standard.

There are gaps for acute inpatient hospital, radiology, laboratory, and hemodialysis with limited potential to resolve due to lack of practicing providers. Potential to meet standards per Attachment F across the state is limited due to known provider shortages.

At this time there are no providers identified with patterns of persistent non-compliance with adherence to Access and Timeliness Standards. Compliance is informed by our Appointment Availability Surveys, member and provider complaints, and front-line staff and are addressed in real time as we uncover concerns to remedy gaps. Using existing network access standards, we currently meet 97% access for all medical specialties and 99% adequacy for all behavioral specialties.

2.6.8.2.3 Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where …

Accelerated Payments. While we are working to address network adequacy and add prospective providers through contracting, we also consider innovative ways to enhance the capacity in our existing network. We took several actions to preserve access when the pandemic forced many providers to close. This included being the first MCO in 2020 to expedite payments to providers in our VBC programs up-front when they needed it most. This financial support helped providers keep their doors open. We also made providers whole for their incentives, matching their 2019 earned amount and paying the difference if their performance increased. We issued over $8.6 million in expedited incentive payments to providers in 2020 with long-term benefits for Louisiana communities.

Clinical Pathways Investment. In 2020, we deployed our Clinical Pathways Transformation Investment Program to address decreased cash flow at FQHCs. Providers received payments for targeted pathways that support building capacity to respond to the immediate needs of the pandemic and afterward. FQHCs chose to dedicate funds to one of the following five pathways based upon the specific needs of their patient population: Healthy Children, Healthy Pregnancy, People Living with Chronic Conditions, Integrating Behavioral and Physical Health, and Addressing the Pandemic. In Louisiana, we invested more than **$1.9 million** to support **19** FQHCs.

Transformation Dollars Drive Access at Innis Community Health Center by Allocating Funds to Mobile Units

"Not just our patients have benefited from the clinic being able to get out into the three parishes we serve, but everyone has had the opportunity to get vaccinated. Our parishes are very rural and so for our clinic to be able to drive to certain areas and have our patients and our community have accessibility has been very rewarding for all of our staff and has been a great service to our communities."

Rachel Nelson, COO, for Innis Community Health Center.

Following is a sample of the many other network capacity-building strategies we look forward to deploying within the next contract period:

Crisis Stabilization: We are actively working with newly licensed crisis stabilization provider, RI International, to secure a contract for adults and have submitted an "in lieu of" form to LDH for additional mobile crisis stabilization services. In addition, we are in discussions with one other

provider who is working to secure a crisis stabilization license. Crisis stabilization facilities provide 24-hour care for those in need of behavioral health services.

Increasing Access to Evidence-based Practices (EBPs): To support and promote the availability of evidence-based practices for our members, we will be launching a provider incentive initiative. Providers who achieve national certification and include EBP tracking codes on claims, will receive an enhanced payment to support the following EBPs: Child-Parent Psychotherapy (CPP), Parent-Child Interaction therapy (PCIT), Preschool PTSD Treatment (PPT), Triple P (Positive Parenting Program) – Level 4, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Youth PTSD Treatment (YPT), and Eye Movement Desensitization and Reprocessing (EMDR).

Louisiana Telehealth Partnerships: During the COVID-19 pandemic, it became clear telehealth expansion was necessary. Supported by our Clinical Pathways Transformation investments, four FQHCs opted to use the funding to expand telehealth capabilities. We continue to build upon these innovations as part of our network strategy, including expanding behavioral health physicians' telehealth and after-hours capabilities, and making prompt updates to the *Provider Directory* for enrollees. Bringing telehealth capability to local providers is a great way to enable local access to care in rural areas without using national and out-of-state telehealth providers.

Physical-behavioral Health Integration: The ability to deliver integrated care is a critical capacity for our network because one in three of our enrollees have both behavioral health and physical health needs. We will support our network in growing this capacity through our quality, population health, value-based payment and provider support functions, providing comprehensive tools, guidance and consulting to promote care integration.

> "We are excited to have the opportunity to partner with UnitedHealthcare to provide holistic and patient-centered behavioral and physical health services to Louisiana Medicaid members."
>
> *- Edward C. Carlson, Chief Executive Officer,* ***Odyssey House LA***

Non-emergency Medical Transportation (NEMT): UnitedHealthcare implemented enhanced reimbursement throughout the pandemic to support NEMT providers and continues to do so today to assure enrollees have access to reliable transportation to obtain the care they need and deserve.

Scholarships: Planning for network capacity requires a long-term plan in addition to short-term strategies. Our Diverse Scholars Initiative assists students pursuing education in the health care field. We have provided $34,000 in scholarships to five Louisiana scholars since 2018. We are establishing a four-year $50,000 scholarship with LSU Medical School for Black in-state students to address the deficiency of physicians of color and will award a scholarship in the first quarter of 2022.

Improving Appointment Availability: Our member service advocates (MSAs) are available to assist enrollees in scheduling appointments with providers. Informed by the resources in 2.6.8.2.5, when we uncover non-compliance with appointment availability or after-hours access to care, our provider advocate team educates providers on actions needed to meet requirements, driving improvement.

Express Access Network: Appointments are available within five days through this subnetwork of clinicians, exceeding the industry standard of 14 days. Providers can easily be located using the Express Access search criteria on our Live and Work Well website or via our toll-free line.

We are a trusted advisor to our provider network and will continue to build upon our longstanding partnerships with providers to enhance access and capacity to high-quality care for our enrollees.

2.6.8.2.4 What you consider to be the most significant challenges to developing a complete Statewide Provider …

The most significant challenges to developing a complete and fully compliant network are lack of provider availability in rural areas, providers unwilling to participate at current Medicaid rates, and providers not meeting the claims threshold requirement in Attachment F.

There are locations in the state without sufficient providers available for contracting to meet access and adequacy requirements for 100% of enrollees. As an example, in the following table from our review in July 2021, there are no additional OB/GYN or Endocrinology providers available for contracting to improve geographical access for enrollees in Franklin Parish.

Region	Parish	Specialty and Provider Type	Total Members	Members with Access	% of Members with access	Met	Pass %	Access Standard Miles
8	Franklin	Endocrinology	2,736	2,720	99.4%	N	100%	60
8	Franklin	OB/GYN	969	814	84.0%	N	100%	30

We strengthen capacity through telehealth with Louisiana providers and providing NEMT while continually monitoring for opportunities to contract with new providers to address gaps.

Compensation is the barrier for some providers requiring rates above Medicaid allowed amounts. To address this challenge, we propose flexible contracts with payment tied to value. Value-based contracting rewards providers for improving health outcomes and addressing health disparities through accountable partnerships and care transformation. Moving away from fee-for-service models and toward pay for performance has resulted in improved outcomes for enrollees.

It is important that the provider network we present to members includes reliable care providers available when our enrollees need services. We understand why the state has added claims utilization to determine whether network providers are truly active. The 25 claims threshold presents challenges and there could be instances when an actively engaged provider is willing to accept Medicaid enrollees but still not have 25 office claims. This could be a result of offering unique or specialized services, cultural accessibility such as primarily serving and speaking a language other than English or ramping up telehealth in response to the public health emergency. With COVID-19 concerns, the use of telehealth with local providers remains a steady and safe alternative for many enrollees. Additionally, there are circumstances where a provider's leave of absence, such as due to medical leave or office closure, could result in a provider submitting claims below the threshold of 25 in six months. That said, we understand the intent of the requirement is to hold MCOs accountable to an effective network and accurate information in our directory, and we will continue to engage in our action plan to work alongside network providers, fill gaps and maintain access for enrollees.

2.6.8.2.5 Strategies (including a description of data sources or tools utilized) for monitoring compliance with the …

Our Louisiana network team meets at least monthly to identify network deficiencies. With the support of the Quality Management Committee, we will continue to use the tools and resources listed below to monitor our network throughout the new contract term.

Appointment Availability Surveys: We randomly select providers for survey calls to determine compliance with requirements. During the survey, the vendor solicits availability for emergency, urgent, routine, and preventive visits. When surveys indicate non-compliance, we conduct targeted

training. Non-compliant providers receive outreach, face-to-face follow-up and, when necessary, a performance enhancement plan. We review opportunities for improvement identified in our **NET 1-3 Report** listed below in this section.

Quest Cloud Reporting: Quest Cloud (i.e., GeoAccess) maps and compares the travel time and distance between the ZIP code of the enrollee's residence and providers' service location to assess adequacy based upon state requirements. Accessibility (time and distance) is measured by the geographic distribution of providers by specialty. This analysis provides insight into the number of providers, by type, and the location of the required specialties, to meet contracted access standards. We conduct ongoing monitoring and ad hoc analysis as needed, for example, when there are changes in network participation of large physician groups.

NET 1-3 Report: Annually, we conduct comprehensive qualitative and quantitative analyses of our provider network, through analyses of: practitioner-to-enrollee ratio; geographic availability; enrollee satisfaction based upon CAHPS survey results, complaints and appeals; practitioner-level survey results, including appointment availability, urgent access and after-hours care; out-of-network analysis, which includes pre-service requests and utilization.

Provider Data Validation: We monitor provider data regularly to confirm providers with closed panels are removed from the *Provider Directory*. Providers with no claim activity within 12 months are evaluated to determine if an update is required or if the location should be terminated.

Monthly Network Variance Tracking: We review utilization against the existing provider network to identify potential recruitment opportunities to support membership needs and to meet access and availability standards. Recruitment opportunities are directed to the network team for outreach. When no provider type is available within a specific parish, we identify care patterns and alternate providers near the enrollee's residential parish to help monitor and facilitate access to care.

Provider Engagement: We regularly engage statewide provider associations, such as the Louisiana Association of Health Plans, Louisiana American Academy of Pediatrics, and Louisiana Academy Family Physicians via our Provider Advisory Committee to solicit their local perspective based upon firsthand experiences serving enrollees. Provider engagement is further supported by our team of nine regional provider advocates who serve as a local point of contact specific to our Medicaid network. Sections 2.6.9.9 through 2.6.9.15 further describe our activities to engage providers.

Community Engagement: Through our numerous community volunteer events and partnerships and our Health Equity and SDOH Collaborative Council, we receive feedback regarding barriers to care in the local community. We continue to build upon these community relationships and have planned ongoing listening sessions to continue conversations and inform our access so that our solutions meet the community-specific needs of our enrollees. Our population health team have identified key CBOs throughout the state and have outreached to these organizations to better understand their resources and capabilities, and potential for partnership.

Input from front-line staff: One of our best sources of information related to the network is our local front-line staff, including community health workers, provider advocates, enrollee advocates and care managers. These individuals have the closest relationships with providers and enrollees and can attain real-time information about access needs. To collect input efficiently, we have online tools

where staff log network opportunities. By listening to our field-based staff and our nine regional provider advocates we address access needs head-on.

Enrollee Advisory Committee (EAC): EAC specifically exists to receive feedback from individuals we serve in Louisiana. Our committee structure provides individuals and family representatives with opportunities to comment on enrollee materials, access to care barriers, health care service topics and health education. Our community partner and EAC member Dr. Shonda Brooks, CEO of the Family Strong Foundation, approached us within EAC for help engaging patients throughout the greater Opelousas community. She requested our assistance creating a platform now known as "Wellness Wednesdays" where SMEs and community leaders dispel myths and share information on COVID-19, and members receive additional health information and vital resources. This platform affords the Family Strong Foundation, its participants, and the community an opportunity to stay connected during uncertain times. Wellness Wednesdays continues with our financial investment and commitment to keeping rural communities informed and connected.

2.6.8.2.6 Strategies for recruitment and retention efforts, particularly in areas where network gaps exist;

We maintain a consistently strong retention rate of **98%** with our network providers, and our partnerships with quality providers remain steady with long-lasting agreements. Considering the vast reach of our well-established network, our expansion strategy has primarily focused on quality improvement and we will continue to work on growing our list of value-based contracts with network providers. Informed by the resources outlined in 2.6.8.2.5 where we identify opportunities for network enhancement, our network team will discuss participation with identified providers and initiate the contracting and onboarding process.

Key Medical Staff Stability
Our chief medical officer, Dr. Julie Morial and behavioral health medical director, Dr. Jose Calderon continue to practice medicine in Louisiana. This perspective allows them to keep the pulse of fellow providers and experience firsthand how our network is performing and provide valuable insight for continued improvement.

We foster retention by actively monitoring pain points and supporting providers to maintain a high level of satisfaction with their network participation. During COVID-19, when many providers were hit hard by the changes to their daily operations and regular appointments, we supported the network through advanced payments to keep them in business. We detail our commitment to supporting our providers further in Section 2.6.9, Provider Support.

Through regular engagement, our team of provider advocates initiate conversations with providers and collaborate on solutions in support of long-term relationships and provider retention.

2.6.8.2.7 Strategies to ensure that your provider network is able to meet the multilingual, multi-cultural and …

Strategies focus on continuous improvement of our existing LA provider network while focusing on diversity — to include multicultural and linguistic congruency — of our providers. We evaluate our provider network to make sure that we can meet the unique needs of the population we serve, including the enrollees' geographic location, language, race, experience, specialty, quality of care standards, ADA compliance, and capacity to accept new patients. We are committed to identifying, addressing, and mitigating health disparities and structural inequities impacting our membership, the health care system and society. Practicing cultural humility is a foundational tenet of our service delivery process, as is supporting and training our network on cultural humility. We are submitting our proposal in October 2021 to achieve NCQA Distinction in Multicultural Health Care.

Our 2021 NCQA network analysis demonstrates 1.4% of our members list Spanish as their primary language and 0.28% list Vietnamese. Currently, **2.2% of our PCPs speak Spanish and 0.19% speak Vietnamese**. One of our strategies is to identify populations that are geographically centralized and then work to align our network providers with the culturally specific needs of that population. We recognize and monitor the need for Vietnamese-speaking providers and provider staff to serve the New Orleans East population, and Spanish-speaking providers and staff to serve the Kenner-Metairie area.

Meeting Multilingual, Multicultural Needs of Members

We partner with ALAS, a New Orleans-based 501c3 organization focused on youth who are experiencing legal barriers to their education due to immigration or criminal court proceedings, many of whom experienced severe trauma early in life. Our partnership will help ALAS connect with linguistically concordant local and telehealth-enabled behavioral health providers and provides funding for ALAS to expand their programs.

We review multiple data points to assess the disability, cultural, ethnic, racial and linguistic needs of our enrollees. These sources include: 2020 U.S. Census data, CAHPS® 5.0H, Network Database reports on practitioner languages and race, and American Community Survey Data Set (2014).

2.6.8.2.8 Details regarding planned protocol for terminating network providers without cause, including how to …

On occasion, we may choose not to renew a provider's contract. Our policy for termination includes:

- Completing a network analysis to make sure there are no gaps created by the termination
- Following UnitedHealthcare policy, which is consistent with LDH and NCQA requirements
- Notifying LDH, its provider management contractor and other appropriate parties of terminations per Model Contract requirements and seeking LDH approval if the terminated provider is in a Health Professional Shortage Area

To minimize the negative affect of provider terminations on our enrollees, we will sustain continuity of care by following these protocols:

- We notify affected enrollees in writing the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt of the termination notice.
- We employ our Provider Recommendation Engine (PRE) auto-assignment process to help locate available PCPs for enrollees affected by a provider termination.
- We notify enrollees of their medical provider assignment and advise them to call the enrollee services center should they wish to make another choice.
- Member service advocates assist enrollees with selecting a new PCP, using PRE and other resources, and will help schedule an appointment with a new provider. For enrollees who need assistance through the transition of care, an assigned care manager helps coordinate the plan of care with the new provider, the enrollee, and any other identified care team to complete the transition.

Our commitment to the State and our members is to have the right network of high-performing quality providers to meet the needs of our enrollees.

2.6.9 Provider Support [812-page limit]

2.6.9.1 The Proposer should offer support to providers in a number of ways under the contract to ensure that …

In Louisiana over the past nine years, UnitedHealthcare has developed a comprehensive, multi-front approach to provide services and support to providers based upon their feedback and how they wish to interact with us (i.e., in-person, telephonic, call center, online). We created a pod approach to address all aspects of provider needs. Our pod approach leverages the strengths of multiple teams to understand the needs and complexities of the provider community in each region. We have dedicated provider support pods for each region. This approach continues to evolve through collaboration, data and listening to LDH and provider feedback. Please see our diagram in Section 2.6.9.1 displaying the pods and other provider support staff.

> "Franciscan Missionaries of our Lady Health System and the entire UHCC Medical Management Team have worked diligently over the last two years with the FMOLHS Case Management Departments and Denial Management Department to efficiently review admission requests and provide the required authorizations to expedite claim reimbursement...They are the clear leader among the current Louisiana Medicaid Managed Care Plans."
> FMOLHS Director, Clinical Denials and Revenue Recovery

Support Provider Transformation

Our revised provider advocate model assigns each of the nine regions a primary, local point of contact who is **100% dedicated to supporting medical providers and behavioral health providers. This represents an net increase of six new dedicated provider advocates.** The provider advocates serve as the lead in each regional pod support. Our nine provider advocates have over 250 years of combined health care expertise. This enhancement further supports our behavioral health integration and improvement approach. This one-to-one relationship between provider and provider advocate gives providers a simple and streamlined experience as part of participating in our network. In addition, we provide easy access and connections to our advocates with contact information in the provider portal. This dedicated team provides an easy escalation point for all providers in their regions to have issues addressed quickly and correctly. Our provider advocates collaborate with providers to resolve day-to-day concerns and are trained and able to speak with providers about a range of priorities, including, but not limited to, physical and behavioral health integration; claims; data sharing; policies and procedures; network contracting; clinical, quality and VBP programs. Our provider advocates facilitate problem-solving by engaging our subject matter experts through JOC meetings, provider visits, virtual and in-person training and many other touch points.

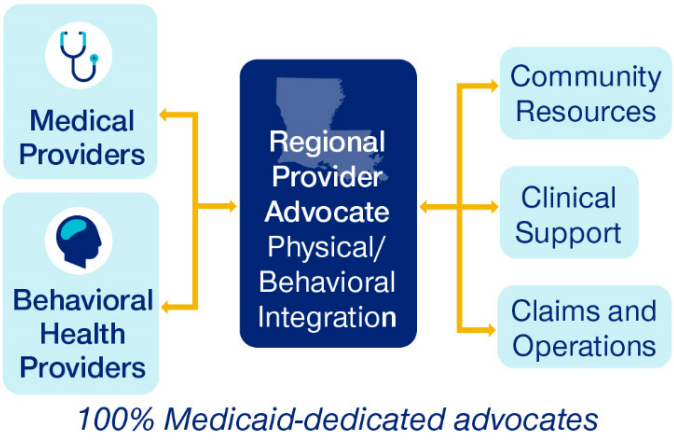

Figure 11. Pod Model. In Louisiana, we enhance provider service quality with our dedicated pod support teams in all nine regions.

To support our nine regional provider advocates, UnitedHealthcare has a range of specialists on population health, behavioral health, quality, VBPs, clinical, claims, pharmacy and many other topics

to provide expertise and support, creating an overall multi-pronged pod approach. This includes a Louisiana-focused team of 31 additional staff who partner with our national subject matter experts covering our national footprint. Our established team and tools support our efforts toward easing administrative burdens and allow our providers to focus on the clinical care of their patients and our members. Each regional pod team meets weekly to review provider trends, claims payment timeliness, network and any other provider concerns and is led by the regional provider advocate at the center of engagement coordination.

In addition to our dedicated pod support team, providers may contact our Provider support call center, where they are helped by support representatives who know not only the Louisiana Medicaid program, but also understand the medical and behavioral health complexities and issues to help resolve.

~~2.6.9.1~~ 2.6.9.1.1 Its process to determine adequate provider relations staffing coverage for the provider network;

Achieve Operational Excellence

Our team of 40 provider support staff, not including our call center teams, comprise our core pod team approach. We acknowledge LDH's clear direction in offering adequate staffing for the provider network to be able to thoroughly and timely address their range of interests and concerns, whether behavioral health or medical. From this feedback, we have increased the number of Medicaid dedicated regional provider advocates by six for a total of nine. In addition, we modified our pod concept by measuring the needs for coverage such as claims volume, VBPs, JOCs, training, provider education, clinical transformation to confirm adequate access to all medical and behavioral health providers in each region. We factor in a one- to two-hour face-to-face interaction with the provider and add travel time, depending upon the provider's location. We will regularly monitor and adjust our staffing plan to meet the needs of our providers in each region. Our call center teams use metrics based upon call volumes and provider network to assure adequate staffing is always in place, including using the greater UnitedHealthcare teams for backup support to ensure business continuity and high-quality service.

Louisiana Provider Support Staff | 66 total supports

Regional Provider Advocates are the local point of contact and serve as the quarterback for the pod team to address provider concerns

Provider support roles	Regional pod teams								
	1	2	3	4	5	6	7	8	9
Regional Provider Advocates	1	1	1	1	1	1	1	1	1
Behavioral Health Provider Advocates	1	.5	.5	.5	.5	.5	.5	.5	.5
Clinical Transformation Consultants	2	1	1	1	1	1	1	1	1
Population Health/Quality Consultants	2	2	1	1	1	1	1	1	1

Louisiana statewide support

- **9** Regional Provider Advocates
- **5** Behavioral Health Provider Advocates
- **10** Clinical Transformation Consultants
- **11** Population Health/Quality Consultants
- **1** Pharmacy Advocate Support
- **4** Network Engagement Support
- **26** Medical & Behavioral Health Provider Call Center

Figure 12. Louisiana-based specialists

The figure displays UnitedHealthcare's team of Louisiana-based specialists on population health, behavioral health, quality, value-based care, claims, pharmacy, and other UnitedHealthcare professionals who provide expertise and resources alongside our nine regional provider advocates.

In addition to time and travel allowance made for staffing, we consider time for high-volume providers to receive additional touch points (in-person, email or call) at least monthly or more as needed or requested to provide education and support and to facilitate resolution of provider needs. We engage these providers through recurring JOCs and other touch points.

~~2.6.9.2~~ 2.6.9.1.2 Strategies to provide effective and timely communications with providers, including the …

We offer numerous ways of communicating with providers in their preferred manner, including face-to-face with our multi-pronged pod teams with a single point of contact, our provider portal, call center, emails and mail to providers. Additionally, providers have easy access and availability to our leadership through escalations or JOC collaborations. Our CEO Karl Lirette, COO Angela Olden, chief medical officer Dr. Julie Morial, and behavioral health medical director Dr. Jose Calderon engage with our provider community weekly or as needed. Our quarterly PAC meetings encourage and cultivate interaction and solutioning with our provider community, including our Louisiana health plan leadership.

During the pandemic, we remain nimble in delivering information to providers via numerous outlets. We share a consistent message with the Louisiana provider community, notifying them of important updates to support their efforts to meet individuals' needs in a quickly evolving environment. We implemented the following successful strategies in Louisiana to engage and educate our provider community which will continue in the new contract term:

Communication Type	Description of Educational Approach	Frequency
Provider Orientation and Onboarding	Full UnitedHealthcare line of business overview for newly contracted providers delivered by regional provider advocates	Within 30 days of contract effective date
On-site Visits	Frequent engagement to foster relationships, maximize performance, issue resolution, promote innovative tools/programs to support administrative efficiencies	Monthly or as needed by request; providers can easily access their regional provider advocate directly
Ask the Advocate	Multi-provider forum designed to educate on targeted topics and provide Q&A with provider advocates	Monthly webinars
Revenue Cycle Service and Education Centers	Mobile revenue cycle service centers allowing providers the convenience of real time investigation into root causes for revenue cycle concerns and data integrity	Ongoing education opportunity by request of provider or advocate based on claims concerns or trends
Computer Lab	Mobile Provider Portal computer labs allowing providers to quickly adopt ease of use with provider portal training. Advocates work with the providers to identify locations based upon portal	By location based upon provider needs; proactive scheduling

	adoption rates or proactive scheduling to bring a provider portal computer lab training to the provider or health system	
Town Halls	Multi-practice forum designed to educate on multiple or targeted topics at various locations throughout the State	Monthly and ad hoc
Webinars	Multi-practice forum designed to educate on multiple topics as well as specific agenda items (e.g., new protocol deployment, reference tools and online on-demand training modules)	Monthly and ad hoc
Provider Expositions	Educational event assembling multiple UnitedHealthcare business units, subcontractors, and external partners in one venue to educate providers on business policies and other useful information	At minimum, two times per year
Operational Meetings and Joint Operating Committees (JOCs)	Operations meetings focusing on operational performance and improvement strategies that ease administrative burdens	Monthly, Quarterly

By communicating effectively and promptly, we have successfully engaged providers through various forms of events and education programs to promote the best care for Louisiana enrollees. On average, over 6,000 providers attend our educational programs and events annually.

~~2.6.9.3~~ 2.6.9.1.3 The processes that the Proposer will put in place to support providers with high claims denial rates;…

Every Friday, leaders from our provider support team and our claims administration team meet to review any spikes in denied claims by provider group. The list of provider groups who had a drastic increase in denials due to billing errors is given to the provider advocates who work with the provider to correct the claims and educate them to reduce their denial rate in the future. Additional methods we use to notify and educate providers of claims and payment include: our provider portal, field-based provider training, webinars, town halls, our *Care Provider Manual, Practice Matters* (our provider newsletter) and Joint Operating Committee (JOC) meetings. In addition to these informative training mechanisms, with the new contract, we will continue to offer the following assistance to our providers with high denial rates:

Process	Description	Result
InterQual	A proprietary literature surveillance system monitors more than 3,000 guidelines; an independent clinical review panel draws from more than 1,000 experts and provides authoritative peer review	More efficient, more transparent clinical decisions with faster turnaround times
Pre-adjudication Smart Edits	Electronic identification of “certain to deny” claims, followed by an alert and education to the provider with instructions to resolve the claim errors	Providers receive feedback within 24 hours of claims submission, helping reduce administrative expense and burden

Care Provider Early Warning System (CP-EWS)	During adjudication, this system uses data collection and analysis to monitor denial volume, denial rates, claim receipts and cash flow	The system alerts us to the risk of claims denied in error and fluctuations in claims receipts and cash flow paid to providers
Provider Advocate Liaisons (PALS)	Targeted support and education for providers regarding claim adjudication	Real-time adjudication for claims
Act 710 Compliance Meeting	Weekly meetings to review the top five providers in all specialties with 10% or higher claim denials	Determines the provider support through education, JOCs for larger provider groups, or face-to-face outreaches

As an example of our process to support providers with high claims denials, during a 2018 quarterly JOC meeting with our largest provider group, we saw the need for additional support. Franciscan Missionaries of our Lady Health System and UnitedHealthcare collaborated in monthly meetings to mitigate the impact of inpatient admission denials. Our chief medical officer, Dr. Julie Morial, along with our provider pod advocate team, provided FMOL with information to assist with authorizations, reimbursement and level of care issues. Since meeting regularly, FMOL has seen a significant decrease in claim denials.

~~2.6.9.4~~ 2.6.9.1.4 The processes that the Proposer will put in place for evaluating and resolving provider disputes in…

Our Louisiana operations team tracks and analyzes provider complaints daily to determine root cause and develops strategies and solutions to remediate future complaints. We use our Impact Pro system, a Salesforce tool, to track provider disputes and have documented 659 cases thus far in 2021. Those cases were resolved in eight days, on average.

- As part of our commitment to minimizing provider disputes, UnitedHealthcare will continuously improve and update internal policy and procedures and facilitate work groups to resolve provider pain points identified through the complaint tracking system. We gather information to focus and tailor our provider education efforts through feedback from provider advocates, provider expos, and provider surveys. With our escalation tracking system (ETS), we have identified and implemented the following procedures to improve our process: End-to-end audit of all single case agreements (SCA) to confirm correct reimbursement
- Expanded claim investigation globally to include all claims and providers when an issue is identified beyond the original complaint

Auto-assignment Disputes: If a provider requests reassignment of an auto-assigned enrollee due to geography, or family of the enrollee has a relationship with a different PCP, we can move the enrollee effective the next business day. We are establishing a dedicated email box for providers to request enrollee reassignments away from their practice and will clearly showcase this information on our provider portal. We acknowledge LDH's monthly claim reports showing enrollee reassignments and an enrollee remaining on a PCP's list even if the enrollee does not visit the PCP. UnitedHealthcare follows federal rules by researching disputes and moving enrollees when valid.

We plan to launch a pilot program to address PCP concerns with enrollees who have not sought care. This pilot will involve select PCPs in Louisiana to locate and engage hard to reach enrollees at high risk (based upon prior claims or diagnosis data) with the next contract. The PCPs will receive an incentive payment for each of the target enrollees who obtain care, verified via claims.

~~2.6.9.5~~ 2.6.9.2 The Proposer should describe how it will support the provider to improve quality and reduce costs …

Our strategies to improve quality and reduce costs start with listening to providers and understanding their current and future goals. We continue to adapt our modular suite of value-based payment (VBP) models while providing technology, education, claims issue resolution and seamless credentialing. Based on provider feedback, in 2018, we redesigned our gap closure incentive programs from paying based on a target achieved to paying per gap closed, with a retroactive bonus once specific targets are met. This supports providers with more real-time payments early in the process when service is provided. Since implemention, we have seen significant outcome improvements in critical HEDIS measures. The text box highlights two examples with diabetes and controlling high blood pressure where we improved quality outcomes. We will add new incentives for 2021 for behavioral health integration and health equity as we evolve our delivery systems.

Our VBP Incentives Lead to Better Health Outcomes

Controlling blood pressure (CBP) and diabetes are prevalent health concerns in Louisiana. We have a significant focus in our VBP incentive programs to improve quality outcomes.

By incorporating interventions such as provider education and engagement, from 2017 to 2020, we achieved over 19-point improvement in CBP and over 14 points in CDC HbA1C (<8.0%).

Our VBP and capacity-building investments enhance the current offerings of our provider network and foster momentum for them along the pathway to increased risk sharing and more integrated support of their population. These goals align with LDH's vision and with our national experience.

In conjunction with our network and operations teams, our quality management committee monitors network performance, addresses opportunities for improvement and communicates follow-up actions. In addition, the QMC supports providers by monitoring provider offices' linguistic competencies compared with languages spoken by enrollees and providing access to interpretive services in addition to evaluating HEDIS® provider data to identify appropriate quality goals.

To improve health outcomes and provider performance, we enable providers to have real-time access to data at the point of service. For example, in addition to our data reporting, collection and analytic capabilities, we developed Point of Care Assist®. Point of Care Assist (POCA) integrates our data directly into the provider's individual Electronic Medical Record (EMR) to provide real-time insights into individual care needs within their existing workflow. This integration allows providers to take immediate advantage of presenting real-time patient eligibility and enrollment at the point of appointment scheduling, enabling real-time chart exchange at time of encounter, and reducing or eliminating chart requests and real-time gaps-in-care information.

~~2.6.9.6~~ 2.6.9.2.1 Strategies to support primary care providers, including but not limited to investments in primary …

Many of our investments in the Louisiana delivery system have focused on building capacity for PCPs, with a particular emphasis on expanding telehealth capability, addressing the pandemic and addressing SDOH needs. Two recent examples to engage our PCPs come from our focus on provider transformation and community catalysts.

To initiate our engagement on provider transformation during the pandemic, we created new pathways to challenge and support our FQHCs to strengthen their practices in areas where they felt they needed additional help. As part of the FQHC transformation initiative, we paid nearly $2 million to support business continuity, capacity building and local telehealth delivery.

In December 2020, we provided Open Health Care Clinic (OHCC) a $250,000 community catalyst investment and funded a collaboration with One-Stop Homeless Service Center (OSHSC). This funded staffing of a behavioral health care manager at OSHSC; and nutrition, housing, and transportation services for OHCC patients with SDOH needs and promotes medical home development.

Addressing the Pandemic
During the early days of the pandemic, UnitedHealthcare demonstrated deep commitment and continued support to Louisiana providers. We were the first MCO to accelerate full VBP incentive payouts according to providers' 2019 or 2020 performance, whichever was higher.

We developed SDOH interventions through our Partners in Health program launched in April 2018 with Daughters of Charity. Through a $2.5 million grant, we supported the hiring and training of 15 Daughters of Charity community health workers (CHWs) who assess at-risk individuals, identify social barriers, and refer and connect enrollees to appropriate community programs and resources. In 2018, CHWs at Daughters of Charity reached 8,234 individuals, encompassing both our enrollee and non-enrollee population. Of those individuals, 5,195 completed referrals to receive medical, dental and behavioral health services through Daughters of Charity health centers.

Support Provider Transformation

~~2.6.9.7~~ 2.6.9.2.2 Strategies to support behavioral health and other specialty providers to participate in delivery …

Elevate Integrated Care

We use multiple strategies to support behavioral health and specialty providers in evolving the delivery system to align with LDH's priorities of more access and coordination of care between medical and behavioral health. We provide more complete, integrated care including value-based payment (VBP), direct investment, and collaborating with providers on innovative delivery models. Our VBPs aim to improve enrollee experience by addressing all aspects of enrollees' care and rewarding practitioners who deliver successful outcomes. We evolve VBP into behavioral health and health equity integration in several ways:

- **Integrated Physical and Behavioral Health Shared Savings:** We are initiating an integrated physical and behavioral health shared savings program with the Louisiana Primary Care Association where we build upon our extensive existing FQHC shared savings models and increased interdisciplinary care coordination with our FQHC partners.
- **Clinical Excellence Program:** This program rewards facilities committed to improvement in quality and efficiency. It measures the rate of readmissions back to an acute behavioral health program and the rate of kept outpatient appointments with a licensed behavioral health provider within seven days of discharge.
- **Local Governing Entity (LGE) Outpatient Shared Savings:** Shared savings are generated when the baseline inpatient PMPM is reduced beyond the 5% risk corridor; thereby creating a shared opportunity pool where providers are eligible to earn up to 40% of the pool (depending upon the number of quality metrics achieved).
- **Follow Up After Hospitalization (FUH):** The FUH identifies members discharged from an inpatient stay and requires a follow-up appointment with a provider within seven or 30 days of discharge. The purpose is to reduce readmission, and connect members with providers. Our behavioral health team contacts 100% of individuals discharged from an inpatient stay. For outpatient providers who participate in the shared savings VBP model, we have seen a 13% improvement in the seven-day FUH measure performance.

Targeted investments to expand providers' ability to address SDOH and promote health equity are another critical component of our support for specialty providers. In August 2018, we provided a $1.2 million grant to Woman's Hospital to implement its Guiding Recovery and Creating Empowerment (GRACE) program, focused on Medicaid enrollees who are pregnant and with SUD. GRACE provides enrollees with comprehensive case management services, connection to social resources, outpatient recovery services, care planning and one-on-one support from providers trained in obstetrics and addictive disorders.

As part of our delivery system reform efforts, we support integration of physical and behavioral care by supplying behavioral health providers with the technology they need to connect with their patients in new ways. Recognizing data access and lack of record integration are barriers to collaborative care, we are investing in enhancements to our CommunityCare portal, in 2022, this will enable behavioral and physical health providers to develop shared individual plans of care.

Behavioral Health Support
"Working with UnitedHealthcare insurance has allowed Louisiana residents with the utmost acute psychiatric needs to get quality treatment in a timely manner. They are able to move quickly and get placement for patients. Additionally, whenever we have had a claims situation come up, the executive team worked with us to make sure our claims get processed."

– Northlake Behavioral, LA

Finally, we work with providers to augment and enhance our methods for connecting enrollees to care. We partner with the American Society of Addiction Medicine (ASAM) to cocreate training to increase ED physicians' expertise to initiate MAT for patients who present with OUD. The MAT-ED learning course is free, offers CME credits and will be available to all ED providers later this year. To promote this delivery model, we are leading a collaborative effort to enable continuity of care by allowing ED physicians to initiate MAT and connect enrollees to outpatient MAT providers and schedule follow-up appointments *before* the enrollee is discharged.

~~2.6.9.8~~ 2.6.9.2.3 Strategies to share provider performance data with providers in a timely, actionable manner.

Currently, more than 86% of the approximately 500,000 enrollees of our Healthy Louisiana enrollees receive care through providers in VBP programs. UnitedHealthcare creates monthly aggregate and provider- and enrollee-level performance reporting.

We align our providers with Healthy Louisiana's quality and efficiency objectives through sophisticated, targeted data sharing with our provider network. Network providers can access the Patient Care Opportunity Report (PCOR) through our provider portal. The PCOR includes group level summary, individual physician, and enrollee adherence reporting of recommended HEDIS® measures and other standardized quality measure specifications. **We provide PCOR reports to providers monthly** and on demand. The report includes member level details, enabling providers to take action based upon the data. Our provider advocates, pod teams and JOC members are available to review PCOR reports with providers. **Our PCOR reports have been so well-received that LDH created the report as the State standard for all MCOs.** Providing practical feedback makes it easy for providers to identify opportunities to reach benchmark goals and making sure each visit is valuable to the provider and enrollee.

Recently, we received feedback from providers participating in shared savings arrangements that our financial performance reporting would be more useful if it was frequently updated. As a result, beginning in 2022, our shared savings reports requiring claims runout will be provided quarterly.

~~2.6.9.9~~ 2.6.9.3 The Proposer should describe in detail its provider engagement model…

In Louisiana, UnitedHealthcare uses a multi-pronged provider engagement model based upon the needs of our local providers and how they wish to interact with us. Our pod approach addresses provider needs as shared in Section 2.6.9.1's diagram. Our pod approach uses multiple team expertise to understand the needs of the provider in each region.

Our newly revised provider advocate model assigns each of the nine regions a primary, local point of contact who is fully dedicated to our Medicaid network supporting medical and behavioral health providers. This one-to-one engagement between provider and provider advocate makes sure providers have a simple and streamlined experience as part of participating in our network.

In addition, we provide easy access and connections to these advocates with contact information in our provider portal. This dedicated team serves as a one-stop-shop for providers in their regions to have issues addressed quickly and correctly. Our provider advocates collaborate with providers to resolve day-to-day provider questions and are trained and able to speak with providers about a range of priorities, including, but not limited to, medical and behavioral health integration; claims; data sharing; policies and procedures; network contracting; clinical, quality and VBP programs. Our provider advocates facilitate resolution of provider needs by engaging subject matter experts through JOCs, provider visits, virtual and in-person training and many other touch points.

Glad to Be of Service!
"As for William, we had the pleasure of meeting him several years ago when he became our first UnitedHealthcare Community Plan representative to actually make office based visits. He consults us promptly on how we can improve the patients' well-being and keep them informed of the treatment plans and programs available. We are very pleased to have William as our representative, hopefully he will continue his wonderful work for many more years to come."

- Office Manager in Vacherie; March 2021

Our provider services call center allows providers to access telephonic support for questions including claim, authorization, clinical and program support. Representatives are versed in utilization management protocol and providers can submit authorization requests and get status on inpatient admissions and authorizations 24 hours a day, seven days a week.

Lastly, we have taken action to prepare for events that have become more frequent in Louisiana, such as tropical storms, hurricanes and the pandemic. We created an additional function with a Disaster Recovery Toolkit for providers and shared through our clinical consultants. The toolkit enables providers to operate a practice remotely and prepare a disaster plan of their own. Also, our provider relations team notified hospitals in high impacted COVID-19 areas of authorization requirement lifts and other supporting information during the height of the pandemic.

~~2.6.9.10~~ 2.6.9.3.1 The Proposer's staff that play a role in provider engagement;

~~2.6.9.11~~ 2.6.9.3.2 The presence of local provider field representatives and their role;

As described previously in Section 2.6.9.1, we use a pod team approach with each team coordinating with our regional provider advocate:

Provider Engagement Teams	Provider-facing Staff
Regional provider advocates	9
Behavioral health advocates	5

Clinical transformation consultants	10
Population health/maternal health/quality consultants	11
Network engagement support	4
Pharmacy advocate support	1
Total Provider-facing Engagement Team	**40**
Medical and behavioral health provider call center team	26
Total Provider Engagement Team	**66**

Our approach is to provide a frequent and regular provider interaction with all of our provider-facing teams. We recently enhanced our approach as described above in Section 2.6.9 when we expanded to our regional provider advocates in each of our nine regions. Their roles and presence are highlighted below:

- **Regional provider advocates:** As quarterback for the team, these advocates are the primary point of contact, building valuable relationships through frequent interactions with providers. They offer opportunities to integrate with specialty providers such as behavioral health, ask questions, give feedback and raise potential concerns. Regional provider advocates work alongside our senior plan leadership, to make sure these groups can put a face to UnitedHealthcare. They meet monthly and on demand with provider groups.
- **Behavioral health advocates:** They take the lead on stand-alone behavioral health providers and supporting regional provider advocates. This team addresses behavioral health provider questions and funnels coordination of care concerns to the appropriate clinical team.
- **Population health, quality, maternal health, clinical transformation consultants:** These teams work with our providers, including accountable care providers (PCMH), on both quality and utilization issues. These clinical teams develop and implement the value-based incentive programs for the providers with the aim to enhance enrollee health outcomes. Our local clinician responsibilities also include HEDIS chart retrieval, medical record audits, PIP projects, new initiatives, and pandemic and disaster response. They meet regularly with our provider groups in office throughout Louisiana.
- **Network engagement support:** Day-to-day activities include reporting, coaching, implementation and problem solving with providers on various networking supports. Contracting and credentialing is supported by a greater network team to confirm all network adequacy and gap closure as defined in the Model Contract.
- **Pharmacy advocate support:** This role will provide support for new single PBM and oversight of medication therapy management, case management, lock-in coordination, 60-day negative change letters for PDL changes, retroDUR, educational DUR and overall member management. This role is our pharmacy director and will engage with all state providers as needed and regularly.

~~2.6.9.12~~ 2.6.9.3.3 The mechanism to track interactions with providers (electronic, physical and telephonic);

Our provider field staff, including provider advocates and clinical consultants, use checklists and regional collaboration sessions to confirm we cover key topics in our provider interactions. We use these primary methods for the meaningful tracking of interactions with our Louisiana providers:

- The Impact Pro system, a Salesforce tool, captures detailed provider interactions — telephonic, physical and electronic — by logging the provider's tax ID for each touch point.

This helps eliminate duplication of provider contact from multiple UnitedHealthcare representatives

- Tracking of registration and attendance records during Ask an Advocate webinars and expos
- Detailed reports quarterly in full compliance with Act 710 consisting of claim adjudication statistics, denied claims by provider and provider education
- Provider Advisory Committee, town halls virtually and in person, and JOCs offer our local leadership valuable opportunities to receive feedback from our provider groups

In the following table, we depict the number of interactions our team had with Louisiana providers over the last year, which are recorded by provider tax identification numbers:

Type	Count
Industry Association Meetings	130
JOC	287
Monthly Touch Base	536
Provider Education	4,484
Provider Information Expo	251
Town Hall	267
Grand Total	**5,955**

~~2.6.9.13~~ 2.6.9.3.4 How the Proposer collects and analyzes utilization data and provider feedback, including …

We review utilization data and provider complaints in multiple meetings to improve our overall provider experience. This information is reviewed at our Provider Advisory Committee (PAC), Healthcare Quality and UM (HQUM), Service Quality Improvement Subcommittee (SQIS) and Quality Management (QMC) committees to identify and address any developing trends in utilization data, claims denials and provider complaints.

Our key operations teams meet monthly to track and analyze population and utilization data, and review provider feedback complaints to determine training opportunities to remediate future complaints. We monitor claim denial volume to identify provider education opportunities from a Top 10 Denials by Provider Detailed Claims Data report.

Feedback from these meetings are reviewed during our weekly cross-functional meetings with our Provider Pod teams. This helps ensure that our direct advocate engagement with providers translates to timely and actionable changes where appropriate, and that providers' voices are heard. Our advocates address issues and measure effectiveness using a plan-do-study-act (PDSA) rapid cycle improvement approach. Our extensive data experience and approach to technical support enables us to meet providers where they are with numerous opportunities to engage with programmatic data and participate in training and education.

Due to provider feedback in 2017, we proactively created a new and simpler way to measure provider satisfaction called the Weather Report. The Weather Report gives providers the opportunity to rank their satisfaction on a simple 5-point scale. The report includes an open text box allowing providers to give direct feedback to our leadership teams. Our leadership team immediately follows up with any providers who ranked their satisfaction below 3. In 2021, we surveyed our medical, behavioral and pharmacy providers who see the most members. The survey response rate was 74%

and the average score was four on a 5-point scale. We also received provider satisfaction scores from our provider NPS survey (see below).

~~2.6.9.14~~ 2.6.9.3.5 The metrics used to measure the overall satisfaction of network providers; and

We value the feedback and surveys from our Louisiana providers. Our regional provider advocates and teams thoroughly review and interact with providers to address any concerns and improvement opportunities. These concerns are brought to our Service Quality Improvement Subcommittee (SQIS) meetings to address survey results in detail. Our comprehensive approach includes defining clear measurable and quantifiable metrics at the macro level (overall satisfaction) and micro levels (satisfaction around specific services and programs), to pinpoint opportunities to improve overall satisfaction. We analyze qualitative and open-ended feedback such as:

Figure 13. Provider Satisfaction. Since 2017, the proportion of providers highly satisfied with our service has improved from 21% to 53%.

- Feedback received through provider training and provider expos
- The Weather Report, performed either in-person or via phone, asking providers to give us a pulse check of their satisfaction
- Emerging trends from provider visits such as policy clarification and reimbursement guidelines
- Provider satisfaction surveys distributed to a rotating, random sample of high-volume specialists representing a cross section of our entire network
- Provider Net Promoter surveys: Since 2017, of the **449 responding providers**, our proportion of highly satisfied (giving a score of 9 or 10) physicians' scores has improved from 21% to 53%
- Periodic Impact (Salesforce) Surveys are performed quarterly to assess satisfaction with our provider advocates. The 2021 results from our largest group, FMOL, rated us a 10 and highlighted their provider advocate as "Knowledgeable, professional," and "Resolved all issues"

~~2.6.9.15~~ 2.6.9.3.6 The approach and frequency of provider training on MCO and Louisiana Medicaid Managed…

We use a proactive, multi-channel approach to provider education focused on comprehensive and timely provider onboarding, re-education, and targeted remediation training and education to address identified gaps. For newly contracted providers our regional provider advocates provide an orientation and onboarding, including Louisiana Medicaid Managed Care Program requirements, within 30 days of the contract effective date. We also conduct provider town halls, webinars and expositions as described in Section 2.6.9.2 which are another opportunity to provide clarification and training on Louisiana Medicaid Managed Care Program requirements. Over the past year, we conducted 252 training and informational events.

Through these successful provider engagement strategies, we have strengthened our relationships with Louisiana Medicaid providers for nearly a decade. Our innovative and forward-looking approach to provider services will remain integral to our ability to maintain a comprehensive provider network, build strong partnerships and improve access to high-quality care for enrollees.

2.6.10 Utilization Management [15-page limit]

2.6.10.1 The Proposer should describe how it will satisfy the requirements for authorization of services set forth…

Our utilization management (UM) program facilitates high-quality, cost-efficient and effective care delivery by confirming appropriateness of care, monitoring and addressing overutilization and underutilization, identifying enrollees who may benefit from care management, and measuring effectiveness. Led locally by Dr. Morial and Dr. Calderon, our program supports providers and improves care. Our UM strategy is informed by Louisiana care needs and our relationships with local providers such as FMOL. Based on our knowledge of the needs of our Louisiana providers, we've created programs such as Point of Care Assist® (POCA) to enable timely and efficient authorizations and Diagnosis to Drug Matching to provide accelerated access to MAT.

A Recognized Leader in Louisiana Medicaid from FMOL Health System (Our highest-volume hospital system in the State)

"Dr. Morial and the UnitedHealthcare Medical Management Team review each case based upon the patient's presentation, comorbidities, course of treatment, socioeconomical factors, and barriers to discharge. They are the clear leaders among the current Louisiana Medicaid Managed Care Plans."

– Nancy Padial, Director, Clinical Denials and Revenue Recovery, FMOL Health System

Authorization Workflow from Initial Request to Final Disposition for Both

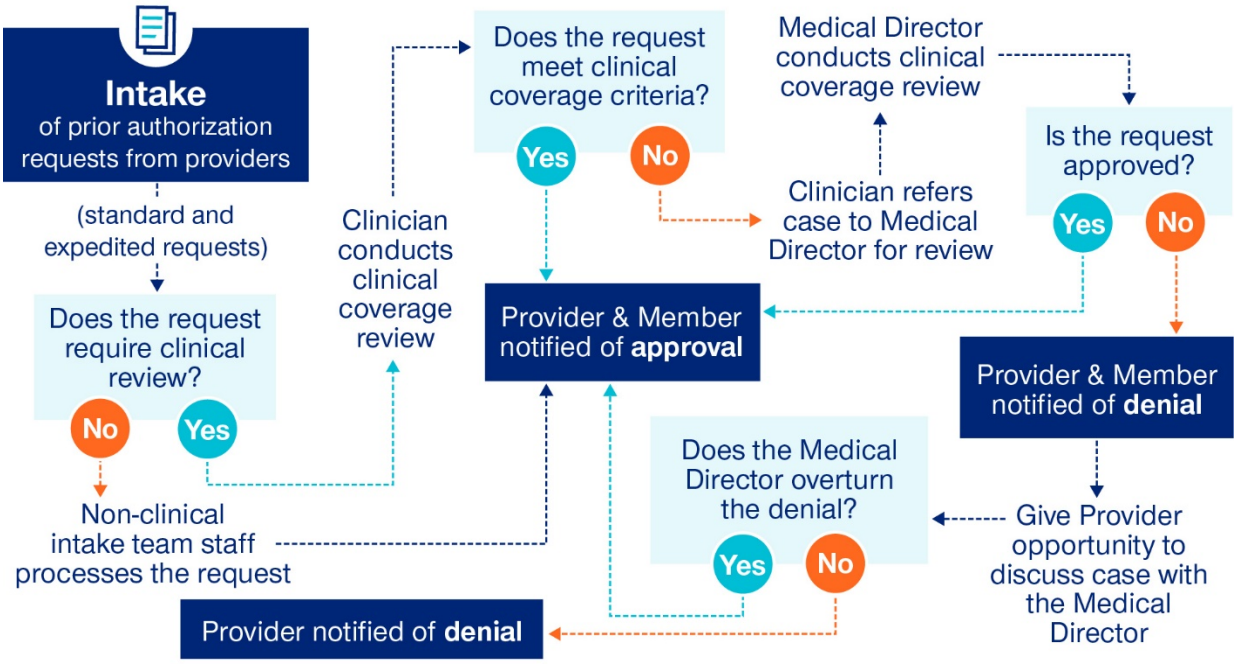

Figure 1. UnitedHealthcare Physician Authorization process meets all Louisiana requirements. The expedited request workflow follows the same process, but occurs within the required time of 72 hours of receipt.

Standard and Expedited Requests

Providers can submit authorization requests at any time. Our service authorization processes meet the requirements in Attachment A - Model Contract, Section 2.12, Utilization Management, including the timeliness requirements in Section 2.12.6 Service Authorization Determination Timing and Notices, with policies and procedures consistent with 42 C.F.R. §438.210 and state laws as well as

regulations for authorization of services. Figure 1 shows our authorization workflow for both standard and expedited requests.

Louisiana providers are using POCA to streamline their workflow, including the use of POCA to process prior authorizations (PA) within their EMRs. POCA integrates into providers' EMRs to submit, monitor, and update PA requests online, simplifying provider workflows and reducing administrative burden. Over 7,000 providers in Louisiana use POCA, and we will soon bring POCA to users of Epic, including many of our largest health systems.

Workflow for Expedited Authorizations

Expedited requests are completed within 72 hours for medical and two calendar days for behavioral health services, in compliance with the requirements in Model Contract Section 2.12.6.2, Expedited Service Authorization. Following a determination, we notify the provider as expeditiously as required based on the enrollee's health condition, but no later than 72 hours after the receipt of the expedited request. We may provide an extension of up to 14 calendar days at enrollee or provider request or if we justify the need to LDH if the delay is in the enrollee's best interest. On-call clinicians are available outside of business hours. Emergencies do not require prior authorization. Our local relationships allow us to urgently respond to providers to make sure their patients can access the services they need. In 2019, our average turnaround time for expedited authorizations was 24 hours.

Pharmacy Authorization

We are uniquely qualified to work with LDH to implement a statewide single PBM. We have recent experience supporting the State of Kentucky in its transition from MCO-based PBMs to a single statewide PBM. We bring that experience to Louisiana — we understand the responsibilities that will remain with the MCO as LDH moves to implement the single PBM. We will administer requirements such as lock-in, MTM, rDUR consistent with the direction from LDH and will adjust to any changes needed as the Statewide PBM is implemented and integrated into Louisiana's Medicaid program.

Provider Education: Drug Utilization Review

As part of a comprehensive Drug Utilization review program to education providers on drug utilization patterns and inappropriate prescribing practices, UnitedHealthcare distributes retrospective DUR bulletins for providers to access on the UnitedHealthcare Community Plan internet page. Recent topics include: *Montelukast FDA Update, Respiratory Therapy and Opioid* and *Buprenorphine Use for Treating Opioid Use Disorder*.

Simplified Intake

Administrative simplification is one of our core focus areas in achieving and ensuring enrollees' ability to access appropriate services and reduce barriers to care. Providers may submit service authorization requests over the phone, by fax, or our secure provider portal. They can submit new PAs and admission notifications, through the portal, check request status and submit updates.

Intake staff validates that requested services are covered and require medical necessity review. Services for enrollees under age 21 are reviewed for medical necessity regardless of whether covered, per EPSDT regulations.

Operational Excellence UnitedHealthcare Prior Authorization Achievement
in 2020 Q1, we marked pre-pandemic success for our enrollees with outstanding prior authorization completion rates for Louisiana:

- **Standard (within two Business Days): 98.84%**
- **Expedited (within 72 Hours): 99.48%**

Determining medical necessity. Our UM program supports integrated medical and behavioral health requests, consistent for all services and programs. A UnitedHealthcare medical director determines medical necessity and appropriateness of care by applying LDH's definition of medical necessity in compliance with contractually covered services as well as clinical practice guidelines, enrollee eligibility, state and federal mandates, and UnitedHealthcare medical policy. For physical health, we use UnitedHealthcare policy and InterQual® criteria, while criteria for mental health services include LOCUS, CASII, and ECSII criteria (except for PRTF, as the State supplemental data supersedes our guidelines for this LOC). For Substance Use Disorders (SUD), ASAM criteria is used.

2.6.10.2 The Proposer should describe how it will satisfy the requirements for utilization management set forth …

2.6.10.2.1 The proposed criteria to use in its utilization management process and how such criteria will be…

Appropriateness of Treatment Guided by Accepted Industry Criteria

We balance recognized industry criteria with locally developed policies to guide our treatment decisions. These **Clinical Criteria** provide medical necessity evaluation methods, taking into consideration interpersonal, social, functional impairment and prior treatment response factors:

- **InterQual®:** To support provider satisfaction and align to community standards, we transitioned to InterQual in 2021 for clinical care guidelines to support our UM program.
  - Where appropriate, we create Louisiana-specific clinical practice guidelines, as we did with private duty nursing in May 2021 with LDH approval and following 45-day public notice subject to the requirements of Act 319.
- **Mental Health:** For mental health, we use LOCUS, CASII and ECSII, which are each designed for different age groups (with the exception of PRTF as the State supplemental data supersedes our guidelines for this LOC).
  - **Level of Care Utilization System (LOCUS):** A standardized level of care assessment tool developed by the American Association of Community Psychiatrists for medical necessity and placement decisions for mental health disorder benefits for adults age 18 or older.
  - **Child and Adolescent Service Intensity Instrument (CASII):** A standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry to make medical necessity determinations and provide level of service intensity recommendations for mental health disorder benefits for 6- to 17-year-old children and adolescents.
  - **Early Childhood Service Intensity Instrument (ECSII):** A standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and provide level of service intensity recommendations for mental health disorder benefits for children ages 0 to 5 years.
- **Behavioral Clinical Policy:** Criteria stemming from evaluation of new services, treatments or new applications of existing services or treatments used to make coverage determinations regarding proven or unproven services and treatments.

- **American Society of Addiction Medicine (ASAM) Criteria:** Determinations for SUD treatment using separate placement criteria for adolescents and adults to support individualized care.
- **Psychological and Neuropsychological Testing Guidelines:** Criteria to make medical necessity determinations related to psychological and neuropsychological testing.

Use of Criteria to Determine Appropriateness of Treatment

A UM representative determines if each service request requires PA based upon our UnitedHealthcare Community Plan of Louisiana predefined and LDH approved services list. Licensed UM clinicians review requests requiring PA to determine medical necessity and appropriateness of care using benefit plan documents, state and federal regulations, coverage determination guidelines and medical policy to verify treatment and site are appropriate for the enrollee. An AUM clinician approves or sends to a medical director if further review is needed.

Our review process incorporates an understanding of unique factors such as: comorbidities or complications, progress of treatment, psychosocial situations, home environment, cultural needs, discharge needs and local delivery system factors (i.e., availability of inpatient, outpatient, transitional or post-acute facilities, availability of outpatient services in lieu of inpatient services). Our UM staff notes if any of these factors weigh into final decisions.

We conduct annual **inter-rater reliability (IRR) reviews** to verify consistent application of medical necessity guidelines. In 2020, our IRR score was 98.69%. All UM staff are trained on these care guidelines and closely monitored through supervisory and IRR reviews to validate their decisions meet standards for treatment appropriateness. Management reviews IRR results and reports to our Quality Management Committee. Staff who do not pass the IRR receive additional training to confirm adherence to best practice standards.

Ensuring Appropriate Site of Treatment

We train our UM staff to review for appropriate site of treatment using inpatient, ambulatory, outpatient and facility-based care guidelines. Staff reviews utilization at the care site, parish and enrollee-level to monitor metrics such as clinically avoidable visits and discussing alternative options with the highest utilizing providers. For example, we know availability of psychiatric residential treatment facilities is limited in many northwestern regions of the State, so our UM staff assess for the least restrictive, most clinically appropriate care (e.g., wraparound services) to maintain an enrollee in their community as a viable option to PRTF admission. Our use of ASAM criteria and Patient Placement Criteria helps us align medical necessity to the appropriate site of care for enrollees who require SUD treatment and our network provides the full continuum of levels of care 0.5–4 detailed within the criteria 2.6.10.2.2.

2.6.10.2.2 The Proposer's process for monitoring and addressing high emergency room utilization;

We developed our **ED Navigator program** to reduce unnecessary ED utilization. The program includes data analytics, dedicated and focused staff, identification of high-risk enrollees, development of innovative programs, and value-based incentives for providers and development of targeted performance enhancement plans. We use Next Health Technologies machine learning and AI capabilities to help us determine the effectiveness of our ED Navigation program to create opportunities for continual improvement. **Our ED Navigator program has reduced ED use by 30%.**

Louisiana ED Navigator Program Data Analytics

We use HealthView Analytics a unique analytic dashboard for key population-level metrics such as avoidable ED use, and enrollees who are pregnant or have opioid use disorder. Within HealthView Analytics, we can view data by parish, provider or at the enrollee level, such as:

- **Hospitals with the largest number of clinically avoidable visits which could be diverted to alternate settings. Enrollees with frequent ED visits** are then connected with primary care providers and behavioral health providers as appropriate
- **Utilization rates per 1,000 enrollees per year by parish** to identify areas with disproportionate ED utilization

Top 5 ZIP Codes for ED Usage Selected for Region			
ZIP Code	# of Members	ADI	% Avoidable ED Visits
70570	1307	7	31.9
70535	542	7	27.5
70512	184	7	30.1
70584	146	5	30.0
70577	122	9	31.8

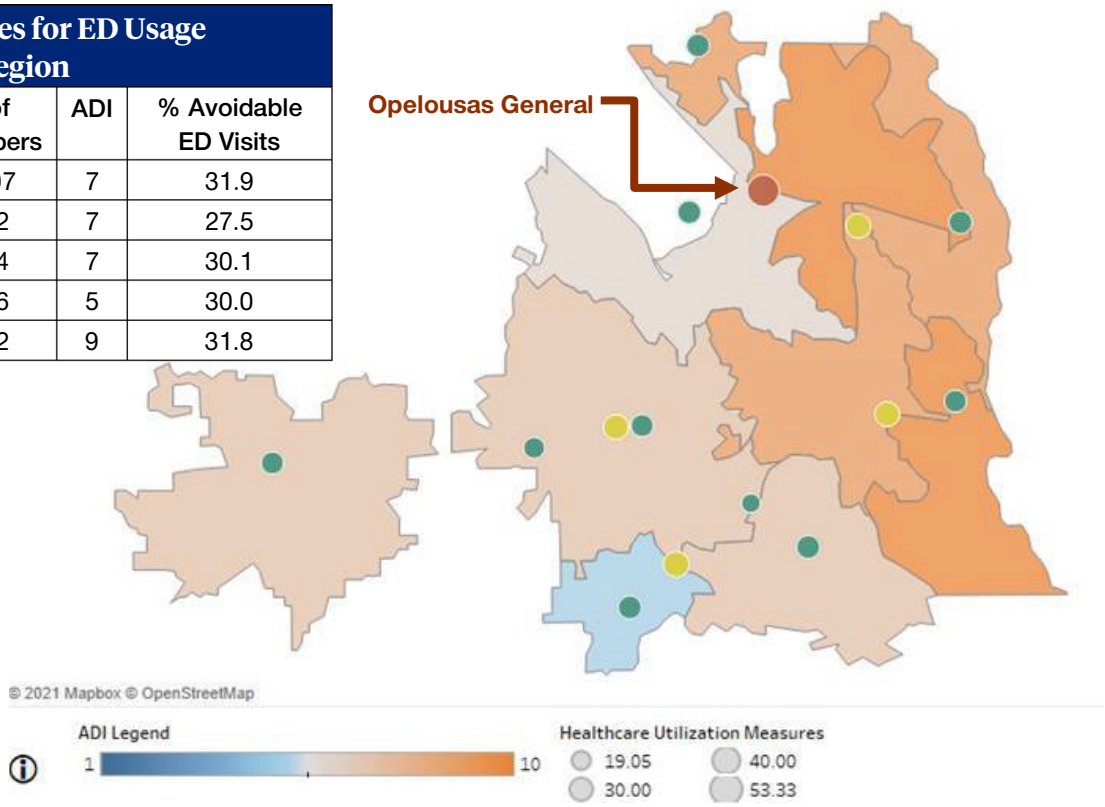

Figure 2. HealthView Analytics shows population-level metrics
(Percent of Avoidable ED visits for adults and children **St. Landry Parish** per ZIP code (Opelousas General illustrated)

Further, HealthView Analytics provides us a view which includes a specific location's Area Deprivation Index (ADI), a multidimensional evaluation of a region's socioeconomic conditions linked to health outcomes, health delivery and policy such as education, housing or transportation. With HealthView Analytics capabilities, we can identify specific ED utilization trends, as the figure 2 shows for St. Landry Parish**. Through use of the HealthView Analytics, we were able to initiate our ED Navigator program with Opelousas General Hospital.** With these powerful analytics, our Health Care Economics (HCE) team analyzes medical, behavioral, and pharmacy claims and social

determinants data to measure the effectiveness of our programs, comparing our performance to nationally recognized benchmarks and standards (such as HEDIS). Analytic reporting includes:

- **Emergency Department Escalation Report** identifies hospitals which tend to admit enrollees from their ED to observation or inpatient care at a higher rate than peer hospitals across Louisiana. We share this data with hospital partners in Joint Operating Committee (JOC) meetings to discuss opportunities for alternative care pathways.
- **Medical Experience Tracking Report (METR)** analyzes how our hospitals perform compared to national and local benchmarks using metrics (such as admissions and/or visits/1,000) to develop performance remediation plans. In 2018, we included Ambulatory Care – ED to our VBP Shared Savings helping reduce ED visits by 6.99 points.

LDH Priority Measures	2017	2018	2019	Cumulative Change
Ambulatory Care - ED Visits/1,000 enrollees	78.36	69.77	71.37	↓6.99

Figure 3. ED utilization has dropped nearly 7% under our VBP add for visits per 1,000.

- **Provider Peer Comparison Reports.** Annually, our provider-facing staff shares Provider Peer Comparison Reports with providers and discusses their utilization rates on select measures compared with their peers.
- **NYU ED Algorithm Tool** targets Low-acuity, Non-emergent (LANE) ED visits, using an algorithm developed with advice of a panel of ED providers and PCPs, based upon examination of almost 6,000 full ED records. This tool characterizes patterns of ED use to infer appropriateness of use and care needs. We then build upon our shared savings partners in managing the high users to decrease ED utilization.

Dedicated and Focused Staff

In 2019, we implemented our Hospital Care Transitions (HCT) team to build relationships with hospitals to support discharge of enrollees with complex needs. The positive response to this program combined with the partnership developed with Opelousas General Hospital, and supported by the insights garnered from HealthView Analytics, led us to expand the program in 2021 to include an ED navigator. The ED navigator uses established criteria to review avoidable ED admissions within the last 24 hours and outreaches to the identified enrollees to review potential alternatives of care and potential referrals to care management, physical or behavioral, or to community-based organizations. The ED navigator works with the enrollee to identify solutions while ensuring the enrollee is connected to a medical home. For enrollees with more complex needs, we connect them to local behavioral health resources or additional behavioral health resources such as Eleanor Health. If the enrollee is already in care management, the ED navigator connects with the care manager (CM) and ICT. If not, and the ED navigator believes the enrollee would benefit from care management, **the ED navigator refers the enrollee to care management and needed physical health or behavioral health such as SUD services**.

ED Navigator Program
Launched in 2021, our ED Navigator program coordinates care and service for patients with a pattern of high ED utilization for non-emergent reasons.

Case Management Drives Improved Outcomes
ED high utilizers experienced utilization changes after engagement in case management:

- A 34% decrease in ED visit rate
- A 26% decrease in IP admit rate
- A 15% decrease in total cost of care

Preliminary data indicates the program has proven effective in mitigating high ED use, with a **24% engagement rate among enrollees** allowing them to be redirected to their PCPs, behavioral health providers, or community resources to address health needs social determinants.

Redirecting an Enrollee to Services

M.M., a 45-year-old female enrollee visited Opelousas General ED for stomach pain. She reports she was admitted for tests for a problem with her pancreas and was scheduled for an ultrasound later in the week. She sees her PCP once a month to monitor her since she is on medication for depression. M.M. says she has manic depression and was going to counseling at Opelousas General but quit after she missed work and lost her job. She says she goes to the hospital when depression becomes severe and has been suicidal in the past. Our case manager helped M.M. reschedule her counseling appointment, established NEMT for transportation, and confirmed a follow up with her PCP to evaluate medication compliance and blood levels. Our case manager also provided her with the behavioral health crisis line number and referred her to our ED navigator.

Identification of High-risk Enrollees

Enrollees identified as having high ED utilization through our IPRO algorithm, Hotspotting tool, provider scorecard or enrollee self-reported data are stratified into our integrated care pod or care management tiers. Our CMs work with enrollees to assess and identify ED drivers such as lack of access to care. The CM, along with the enrollee, their providers, and ICT as appropriate, develop an interdisciplinary care plan to make certain enrollees have access to needed services and supports and understanding of how to access the right care, in the right setting, at the right time.

Our proprietary Hotspotting tool identifies regional trends as well as individual enrollees with unnecessary utilization patterns, complex needs or high costs, allowing our local pods to quickly deploy highly targeted, localized interventions within defined regions of Louisiana. We use the tool to identify enrollees who may have patterns of high utilization (ED, inpatient) to determine the root cause of the patterns. Where the issue is enrollee-specific, the Hotspotting tool provides actionable care opportunities for the CM as they to support the creation of an enrollee-centered care plan.

Our Hotspotting dashboard filters enrollees by demographics, social determinants, utilization, cost, diagnosis, risk factors, and enrollment in care management and other programs. The individual enrollee view provides a 12-month record of IP, OP, ED and Rx utilization, and plots these services according to their service dates for insight into recent changes.

Development of Innovative Programs Targeting Appropriate Access

Through years of experience providing care in Louisiana's communities, we have developed not only an understanding of local needs but also relationships with the local service providers who can address those needs. We have developed a suite of services to allow enrollees to choose the access point that works for them as an alternative to ED use. These include telephonic support, in-office visits and virtual visits, as well as in-home support.

Enrollee Services, NurseLine and Behavioral Health After-hours Call Center. Our enrollee services representatives help enrollees access appropriate services. NurseLine provides 24 hours a

day, seven days a week telephonic access to RNs who educate enrollees about their conditions and appropriate health care services. For enrollees experiencing behavioral health crises, we operate a behavioral health crisis line 24 hours a day, seven days a week staffed by licensed behavioral health clinicians who can assess and triage enrollees to local providers.

Express Access. Our Express Access subnetwork of behavioral health clinicians have contractually agreed to meet a five-day appointment availability. Enrollees can call the toll-free number or use our online provider search tool to identify one of the 64 Express Access providers in the Louisiana Medicaid network. We will educate and invite other Louisiana providers to expand this network.

Robust Network of Louisiana Based Providers for On-demand Tele-support Available Through Our Member Portal

Telehealth Directory Identifiers. In Q4 2021, we will add an icon in our *Provider Directory* to indicate providers who offer telehealth.

Behavioral Health Virtual Visits. Our Virtual Visits program connects enrollees with a Louisiana psychiatrist or therapist using secure videoconferencing via smartphone, tablet or computer or in a provider's office. Clinicians can evaluate and treat a spectrum of mental health conditions, provide therapy and prescribe medications, with some providers offering evening and weekend hours to increase enrollee service access in urban and rural areas.

Year	Enrollee Count	% YOY Change
2018	1,962	57.8%
2019	3,104	58.2%
2020	37,711	1114.9%
2021 (Jan-May)	In only five months, 25,524 enrollees have had a virtual visit — over 67% of the volume of virtual visits for 2020.	

Figure 4. UnitedHealthcare telehealth use has soared among our enrollees.

In-home Paramedicine Programs to Address Access for Urgent Needs

Acadian Ambulance. Acadian Ambulance has local knowledge and focus, with a commitment to the communities and individuals they serve. They **provide a toll-free line exclusively for UnitedHealthcare enrollees and providers.** Available 24 hours a day, seven days a week, they make an in-person visit to address an enrollee's current condition when the enrollee is not in acute distress or in need of emergency services. They can assess the enrollee and Treat in Place (TIP) by initiating a telehealth visit or transport the enrollee to the ED or an alternate destination such as an urgent care clinic, orthopedic clinic or behavioral health hospital based upon clinical judgement.

Ready Responders. This network of trained EMTs, paramedics and nurses visit high-risk, difficult-to-reach enrollees with unnecessary ED utilization. They connect enrollees to PCP specialists, behavioral health services and telehealth consults. They monitor prescription adherence, evaluate risk factors for ED use, and provide counsel in appropriate health care service settings. We conduct weekly rounds with Ready Responders to discuss each enrollee's case and closing care gaps. Ready Responders has seen over 1,900 enrollees with co-existing physical and behavioral health diagnoses. Enrollee utilization in Ready Responders has increase by 225% since the beginning of 2020.

Performance Enhancement Plans (PEPs) for Unnecessary ED Utilization

When high rates of unnecessary utilization are identified, we look broadly at the facility and at the primary care doctors and community resources that could be contributing to unnecessary ED

utilization. We may work with PCPs to deploy telehealth or expanded hours to make certain their enrollees have alternatives to their needs which can be met outside the ED.

Performance improvement plans for identified providers address the underlying drivers of unnecessary utilization including expanding access availability of services and awareness of services. Action items range from clinical guidelines training to provider toolkit development to provider incentives and peer-to-peer coaching as needed. If the issue is systemic, we address the issue in our enrollee materials or in our *Care Provider Manual* and newsletter. We recognize the lack of community resources can lead enrollees to seek resources at the ED that may be otherwise available. Our action plan includes educating providers about the availability of our Aunt Bertha tool. This tool allows our CMs to identify and connect enrollees directly with services to address SDOH.

2.6.10.2.3 The Proposer's process for Pre-Admission Screening and Resident Review (PASRR) and concurrent…

Pre-admission Screening and Resident Review (PASRR) and concurrent review promote continuity of care, confirm appropriate utilization, manage length of stay and facilitate collaboration among the UM clinician, CM, inpatient facility and multidisciplinary team. Since 2019, we have conducted 1,767 PASRRs — 498 in 2021 alone.

When Level I PASRR screenings have positive indicators for possible serious mental illness (SMI), Intellectual disability (I/DD) related condition (RC), or a significant change in condition, UnitedHealthcare completes a PASRR Level II evaluation within four business days.

The evaluation process determines the most appropriate and least restrictive placement for enrollees including recommendations for services. When a nursing facility (NF) is the right option concurrent PASRR resident reviews are completed annually or when there is a change in condition to ensure the most appropriate setting and if the enrollee is receiving the services they need in this setting.

Enrollees who are diverted from NF placement are assigned a UnitedHealthcare behavioral health advocate (BHA) (or if after January 2022, a community case manager [CCM]) who links the enrollee with alternate services individualized to the enrollee's needs to maintain community tenure. Linkages may include physical and behavioral health services, specialty services and community resources.

When enrollees are **transitioned** from an NF, the BHA/CCM works with the enrollee and My Choice LA coordinator to support transition into the community. For both diverted and transitioned enrollees, the BHA/CCM continues engagement and coordination of services until all gaps are closed and the enrollee is connected to all appropriate resources for a year or longer, as needed.

PASRR Success Story

D.S., a 60-year-old female enrollee with major depressive disorder, generalized anxiety disorder and multiple comorbidities was referred for a PASRR while in a nursing facility and identified as DOJ. Previously residing in Vermillion Healthcare Center from January 2018 to July 2020, D.S. reported mental illness since childhood. She had had multiple surgeries related to her comorbidities. Upon discharge from Vermillion Healthcare Center, she became eligible for the DOJ program as part of transition back into the community from the nursing facility.

Interventions. A BHA coordinated services for D.S. to resume mental health services with Compass Mental Health post-discharge. The BHA verified housing program referrals were completed in time for D.S.'s outreach and facilitated referrals to UnitedHealthcare Mom's Meals. Once D.S. began community integration, the BHA supported her by completing scheduled touch points to make sure she was successful in her new environment. Before Hurricane Laura, the BHA completed disaster planning, working with D.S. to identify an evacuation plan, which helped D.S. build her confidence in continuing to live independently.

Outcomes. D.S. was discharged from the nursing facility in August 2020 and began receiving Mom's Meals two to three days after returning home. Post transition, she reported feeling "awesome and blessed" she was able to return home and into her community. Currently, her behavioral and physical health are stable, she attends outpatient mental health services consistently, and she recently got a new puppy.

2.6.10.2.4 How the Proposer complies with mental health parity requirements; and

Mental Health Parity Program

Our Mental Health Parity (MHP) program consists of a series of principled standards, the continuum of policies and processes associated with MHP according to applicable federal and state specific laws and regulations and the integration of parity processes into our business operational practices.

Our financial and clinical models align with the requirements found in the Mental Health Parity and Addiction Equity Act (MHPAEA) and the subsequent release of Final Rules for Medicaid and the provision of quality care for our enrollees. Key elements include, but are not limited to:

- Consultation and recommendations on MHPAEA adherence, as specified in the benefit plan
- Confirming medical management techniques applied to MH/SUD and M/S benefits are comparable and applied no more stringently
- Ongoing analysis of policies, processes and outcomes data to enable parity in operations
- Annual and new hire MHP training for all affected staff
- Quality and adherence monitoring for the detection of potential improper practices
- Quantitative treatment limit annual attestation
- MHP governance structure provides direction, reviews adherence and quality monitoring results, and identifies any process improvements

Nonquantitative Treatment Limits

To comply with MHP regulatory requirements, we instituted designated cross-functional NQTL workstreams accountable for the MHP work in their NQTL content area (clinical, network, payment integrity, pharmacy and benefits) under the supervision of our MHP governance structure. The workstreams include M/S and MH/SUD operational and parity subject matter experts. We monitor MHP adherence through workstream review of policies, operational processes and associated outcomes data. The workstreams review changes to national and health plan-specific policies and processes and complete evaluation of the changes' effect on parity. Workstreams' analysis includes:

- Assess, review and update documentation of new strategies

- Review and update documentation and confirm the definitions are used in a consistent manner for M/S and MH/SUD
- Review and update documentation to compare all evidence and sources used to create M/S and MH/SUD clinical policies, including why external sources were selected
- Review and update the comparison of the M/S and MH/SUD processes used to select criteria
- Update P&P documents to illustrate the comparability between M/S and MH/SUD in key areas to demonstrate parity adherence and no-more-stringent applications
- Retain documentation of key historical changes relevant to tracking parity comparability and stringency testing
- Evaluate medical necessity criteria, P&Ps to make sure more restrictive requirements are not applied to MH/SUD benefits and services than to M/S benefits and services
- Identify data parameters, metrics and design data collection tools in support of comparability and stringency testing. Review outcomes data at least annually or more frequently if indicated

Mental Health Parity Dedicated Resources

UnitedHealthcare has a dedicated MHP team, accountable to Dr. Calderon, whose primary responsibilities include overseeing, managing and maintaining the organization's MHP infrastructure and processes in support of MHP adherence. This team works collaboratively with other health plans, lines of business and national functional partners, such as clinical services, adherence, regulatory, legal, pharmacy, network, benefits and payment integrity.

Mental Health Parity Training

Annual and new-hire training on MHP is provided to all employees, directors or other governing body enrollees, agents and other representatives engaged in functions subject to federal or state parity requirements or involved in conducting MHP analyses.

Quality and Compliance Monitoring

The MHP team conducts regular assessments of ongoing MHP adherence and continued functioning consistent with our MHP Program documented processes.

Mental Health Parity Findings

Our findings reveal the factors and evidentiary standards applied to M/S and MH/SUD benefits and operational policies are comparable in writing and applied no more stringently. Additionally, analyses of the associated NQTL measurable metrics reveal comparable outcomes in operation. As a result, the plan concludes MHPAEA comparability requirements are satisfied.

2.6.10.2.5 How the Proposer identifies and mitigates over-utilization, including any targeted categories.

We identify overutilization using reporting and analytical tools such as HealthView Analytics, Impact Pro, Hotspotting and others described above. Our mitigation techniques are multi-pronged, with enrollee-, provider- and population-level approaches. Targeted categories include:

Success in Pediatric Special Needs Services

The UnitedHealthcare Pediatric Specialty Program team monitors and assesses pediatric special needs enrollees through CMs and review of PA for services such as Private Duty Nursing (PDN), Pediatric Day Health Care (PDHC), and EPSDT Personal Care Services (PCS). When a child is medically stable and ready for transition into a lower level of care or more traditional setting, CMs

educate and instruct parents or caregivers on options and opportunities to transition the child into childcare programs or public schools which are developmentally appropriate to care for and support the enrollee's medical, social and academic needs. We have established statewide partnerships with childcare advocates and development centers such as the Goldman School in Shreveport and Head Start centers statewide and continue to identify partners equipped to safely support transitioning special needs enrollees from the Specialty Program into traditional settings.

UnitedHealthcare Spearheads Statewide Mitigation of Vitamin D Testing Overutilization

After identifying a pattern of the overutilization of vitamin D testing, we engaged the other MCOs at a Louisiana Managed Medicaid Association meeting. Following our lead, the other MCOs identified the same overuse — some at even higher rates than we were experiencing. The resulting policy change requires coverage of vitamin D testing; care providers must include a corresponding ICD-10 code quarterly when they submit claims for vitamin D testing. If an enrollee doesn't meet the diagnosis criteria at the cadence requirement, vitamin D testing is not covered. UnitedHealthcare was the first MCO to follow the same process successfully in 2019 with a new drug testing policy. Additional approaches are outlined in 2.6.10.3.1.

2.6.10.3 The Proposer should describe its historical experience with utilization management of comparable…

We have nine years of UM program experience in Louisiana (inclusive of CCN Shared Savings Network) and have grown and evolved our program in alignment with the changes to Medicaid. Nationally, we have extensive experience performing UM functions for Medicaid and D-SNP programs in 31 states and the District of Columbia, including integrated physical and behavioral. This includes performing UM functions in 24 states that serve children (over 3 million), 24 states that serve enrollees receiving TANF (over 3.6 million), 22 states that serve ABD enrollees (359,000) and 18 states that serve Medicaid expansion enrollees (1.4 million).

2.6.10.3.1 Challenges identified with high utilization and increasing medical trends;

In Louisiana, our highest pre-COVID-19 pandemic trend drivers include ED utilization and an increase in Level 4/5 coded ED visits, with several facilities billing 60% ED claims at these levels. Recent data shows an emerging trend in inpatient admissions for mental disorders, increasing 23% from 2019 to 2020 and 53% from 2019 to Q1 2021. We have developed focused initiatives to address both increased ED use and increasing behavioral health admissions.

Challenges We Identified with High Utilization and Increasing Medical Trends

Accidental drug overdose and ED recidivism. Publicly available data shows accidental drug overdose driving ED recidivism up to 75%, during 2019-2020, including 1,140 drug overdose deaths reported in Louisiana according to WDSU News — the largest increase in the country, with public health officials in Calcasieu Parish calling the deaths "an epidemic." This trend has not slowed with the COVID-19 pandemic; the CDC reports a 52% increase in OD deaths in Louisiana. On average, UnitedHealthcare is seeing an increase of nearly 200 overdose-related ED admissions per month among our enrollees.

OUD is a Leading Driver for ED Recidivism

- Of enrollees with 5+ ED visits, 10.5% have OUD
- Of enrollees with 10+ ED visits, 17.3% have OUD
- Enrollees with 20+ ED visits, 30% have OUD

To address this public health crisis, we are piloting a program encouraging MAT in the ED as an opportunity to engage enrollees in the setting where they are most open to seeking and receiving help. Orleans Parish is an area with a high number of opioid overdoses, and we have developed a value-based arrangement with DePaul Community Health Centers. While many providers saw decreases in MAT continuity during the pandemic, our partnership with DePaul resulted in nine out of 10 individuals refilling their MAT Rx monthly and over 50% of participants continuing MAT for six consecutive months or more without gaps, resulting in a 48% reduction in ED visits. Additionally, we are working with University Hospital, a local high-volume ED, and five other outpatient MAT providers to streamline a process for MAT initiation with a warm hand-off to a qualified MAT provider. Further strengthening the collaborative efforts and resulting outcomes, with ASAM we co-created a MAT-ED training for providers — to be offered free to all ED providers in Louisiana — as well as an ED incentive for MAT initiation. In 2022, we plan to expand this pilot program to other areas of the State.

Acute Behavioral Health Readmissions

We initiated **RACI (Reducing Admissions with Collaborative Interventions),** to both reduce acute behavioral health readmissions and increase community tenure for individuals with complex needs. Through local community partners such as Brentwood Hospital, River Oaks Hospital Covington Behavioral Health, and Odyssey House, RACI has improved communication with inpatient staff and increased collaboration in care, resulting in proactive identification and management of the individual's needs with an **estimated $427,000 in cost savings**. Enrollees involved in RACI have benefited from a **48% reduction in 30-day readmits, a 30% reduction in 90-day readmits and an 18% improvement in 90-day community tenure**. Together, these results indicate utilization is directly — and appropriately — affected by RACI.

2.6.10.3.2 Initiatives undertaken to manage high utilization;

ED Navigator Creates Savings
In 2021, enrollees in our ED Navigator program demonstrated a reduction in ED visits of 1.6 PMPY.

We have initiated projects such as ED Navigator and Shared Savings to address areas noted for high utilization drivers. Seeing the need to manage high ED use in our Louisiana communities, our **ED Navigator program** has been initiated to manage high ED utilization. Early results suggest it is effective in mitigating high emergency department use, with **a 24% engagement reach among enrollees and 30% reduction in ED utilization**. In 2018, we redesigned our overall VBP program approach adding Ambulatory ED visits/1,000. This inclusion helped drive an improvement of 6.99 points from 78.36 in 2017 down to 71.37 in 2019 pre-pandemic.

A Shared Savings partner since 2015 with over 4,000 UnitedHealthcare enrollees has seen a reduction in ED visits of 5%, a reduction in IP hospital days of 56%, and a reduction in Newborn Intensive Care Unit days of 79% from CY2017 and CY2019.

2.6.10.3.3 Initiatives to address use of low value care;

The plan has selected the **Choose Wisely** model to address low value care. Our membership data has pointed us to address low back pain, antibiotic use in respiratory concerns and cervical cancer screening inappropriately.

In 2019, we identified two specific low value of care opportunities, vitamin D and viral respiratory panel and engaged the other MCOs to build consensus on how to support our shared networks in reducing these low value care costs through both claim edits and provider education. We continue to replicate the same approach to address low value care opportunities identified in Appendix H. Specific examples of how we will address these low value care opportunities include provider education through Joint Operating Committees (JOCs), population health consultants support for providers, as well as providing education on evidence-based and value-driven alternatives to reduce the use of low value care.

2.6.10.3.4 Initiatives to address long term stays of enrollees in the ER based on limited availability of …

Based on our experience in Louisiana, we know there are three key drivers of long-term stays in ED:

- Individuals with complex needs or special situations (such as COVID-19 surge)
- Lack of available inpatient or residential care
- Lack of enhanced services needed to address enrollees with special needs

Individuals with complex needs or special situations. We negotiate single case agreements with providers to provide additional reimbursement to meet enrollee needs. Example: An enrollee who has a history of violence against staff had been denied admission to several facilities. We worked with Northlake to secure a bed and negotiated a unique rate to allow Northlake to be able to sufficiently staff to provide the support the enrollee needed while providing for the safety of the staff.

Lack of available inpatient or residential care. We work directly with our network providers to find availability and as necessary, leveraging our provider relationships until we find an available bed, even out of state (as a last resort). We:

- Urgently escalate to the ICT which reviews the specific needs of the enrollees to enable the team to seek appropriate placement
- Engage our ICT team, including our CMO and medical health director outreach to in- and out-of-network providers and facilities to identify availability or solve barriers to placement

The ICT creates solutions to address financial or other barriers to enable the safe transition of enrollees. We provide appropriate education to the providers to make certain they have the capacity and capabilities to meet enrollee needs and will negotiate amendments or single case agreements (SCAs). For example, we provide education to providers and facilities regarding appropriate use of PPE and disposables to support the transfer of individuals with a positive COVID-19 diagnosis.

2.6.10.3.5 Initiatives undertaken to support providers with high prior authorization denial rates.

Providers with High Denial Rates

Our regional provider advocates and clinical teams identify high PA denial trends and work directly with those providers to develop individualized solutions. Our clinical and UM teams determine denial root causes and factors that affect adverse determinations. Our provider advocates discuss causes, provide education, and offer tools and education as needed to providers through webinars, town halls, newsletters, and our *Care Provider Manual* and monthly Provider Network Bulletins.

Standard Process to Identify Providers with High Denial Rates

Monthly, our leadership, led by Dr. Morial, meets to review PA data, including trends, volume denial rates, overturn rates and overall persistency. We look for trends in denials on both the service level

and for specific providers. We closely monitor our overturn rates to confirm we are appropriately administering our PA processes, including overall persistency.

When we identify a provider with a high rate of PA denials or emerging denial trends, we analyze the underlying data to identify the reasons and assist those providers through education and support on medical policy and PA processes. When we identify specific service types with emerging trends or high overall denials, we review our medical policy to validate that it reflects Louisiana-specific needs, and we review the policies on our provider portal to confirm we are clearly documenting our PA processes. For high volume and large providers, we hold regular JOCs to review detailed PA and claims data and collaborate to ease provider burden and verify the accuracy of our processes.

We further support our providers through provider advocate engagement, addressing drivers of administrative denials with our COO, Dr. Morial and Dr. Calderon providing outreach and education on clinical adverse determinations.

Provider Support Tools

We developed our PA and notification portal to avoid adverse determinations and reduce PA denials due to missing or incomplete information. Providers leveraging POCA may handle the full PA process within their own EMR, further reducing their administrative burden.

We give our providers electronic tools that are easy to use and improve provider satisfaction.

- More than 62% of all PA requests are submitted to UnitedHealthcare via a paperless, electronic channel
- Seventy-eight percent provider satisfaction in their ability to complete, manage and track submissions online

To minimize PA denials, when incomplete information is furnished during PA intake, at any time during the process our UM team accepts information to clarify the enrollee's clinical condition. In addition to formal appeals, we offer an informal **reconsideration process to facilitate earlier resolution of requests and reduce the number of adverse determinations**. Similarly, our qualified medical directors perform **peer-to-peer consultation** to support decision making, including reviewing requests that do not meet coverage criteria for medical necessity.

Decision-making Support and Education

On May 1, 2021, we transitioned to using InterQual® clinical criteria to support physical health service determinations and consistency in decision making. Information about the guidelines is available to providers on *UHCprovider.com*. We maintain **Healthcare Professional Education and Training**, a learning platform where providers can watch Louisiana-specific programs on demand, helping them submit complete and pertinent clinical information as requested while improving efficiency and accuracy for online submissions and decreasing service denial rates.

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2.6.11 Quality [15-page limit; clinical practice sample guidelines, NCQA ...

2.6.11.1 The Proposer should describe its organizational commitment to quality improvement and its overall…

No. 1 in Louisiana
UnitedHealthcare is the **highest-performing MCO** in the State:

- **Top score** in MY2019 on 18 LDH-defined quality measures
- **Second-highest scores in 12** out of 58 additional measures
- **Top score** in MY2018 on 22 out of 49 LDH-defined measures

UnitedHealthcare of Louisiana's commitment to improving the quality of care and service to our over 500,000 enrollees is evidenced by our consistent first or second place rank on the Louisiana Department of Health's (LDH's) priority quality measures, and our NCQA rankings. Still, we recognize our state is ranked 50th in health outcomes by America's Health Rankings, and we must continue to pursue innovative and creative approaches to better the health of all Medicaid enrollees in Louisiana. We **will do this by building upon our population health-based quality improvement strategy, using person-centered, integrated solutions to address enrollee needs at all points along the care continuum. We will give specific focus to disparities and priority social determinants of health** (SDOH), in alignment with the Louisiana Medicaid Managed Care Strategy for 2021 and beyond.

Our Quality Champions
Led by Angela Olden, MA, BSN, RN, chief operating officer, Julie Morial, M.D., chief medical officer, and Deborah Junot, BSN, RN, quality director, our staff have the knowledge and certifications to be Quality Champions. This team contains three CPHQ certified RNs, five master's-prepared RNs, one pediatric nurse practitioner, and one HIV certified RN, along with other exceptional RNs who provide education and knowledge-sharing to clinicians throughout the areas in which they reside.

Our Commitment to Quality Improvement

UnitedHealthcare has more than 40 years of experience improving health for Medicaid populations nationally and has served Louisiana Medicaid enrollees since 2012. Our commitment to quality begins with our CEO, Karl Lirette, and our executive leadership staff, where we employ a multi-pronged (enrollee, provider and community-level) strategy **to identify and address needed improvements in the quality of care delivered to enrollees in the Louisiana Medicaid Program and the Louisiana Children's Health Insurance Program.** Our Quality Assessment and Performance Improvement (QAPI) Program integrates quality improvement science with population

Demonstrated Quality Improvement
In 2018, we added CBP to our provider incentive measures list. We recognized enrollee health challenges and multiple confounding factors which influence health outcomes, including COVID-19 and the fact that **hypertension and diabetes remain prevalent throughout Louisiana**. By incorporating interventions such as provider education, **we achieved over 19-point improvement in CBP and over 14 point in CDC HbA1C less than 8** from 2017 to 2020.

Measure and Data Element	HEDIS® 2017 Rate	HEDIS® 2018 Rate	HEDIS® 2019 Rate	HEDIS® 2020 Rate
Controlling High Blood Pressure	37.96%	44.53%	50.85%	57.42%
Comprehensive Diabetes Care HbA1C (<8.0%)	36.5%	41.12%	50.36%	50.36%

health and health equity concepts, and incorporates State and federal requirements, Louisiana priorities and NCQA standards.

Our well-established Louisiana-based Integrated Population Health Quality team provides sustained and meaningful quality improvement through organizationwide engagement and collaboration with all stakeholders including enrollees, LDH, providers, community-based organizations and other MCOs. Our Population Health Quality team drives the Quality Performance Measures (Attachment H) to achieve the validated outcomes — **we do not compete to deliver better quality for our enrollees, we collaborate to improve Louisiana's health system**.

Louisiana Medicaid's Quality Strategy and Priority Quality Measures

Overall Approach

We proactively identify and improve disparities in population health outcomes to advance health

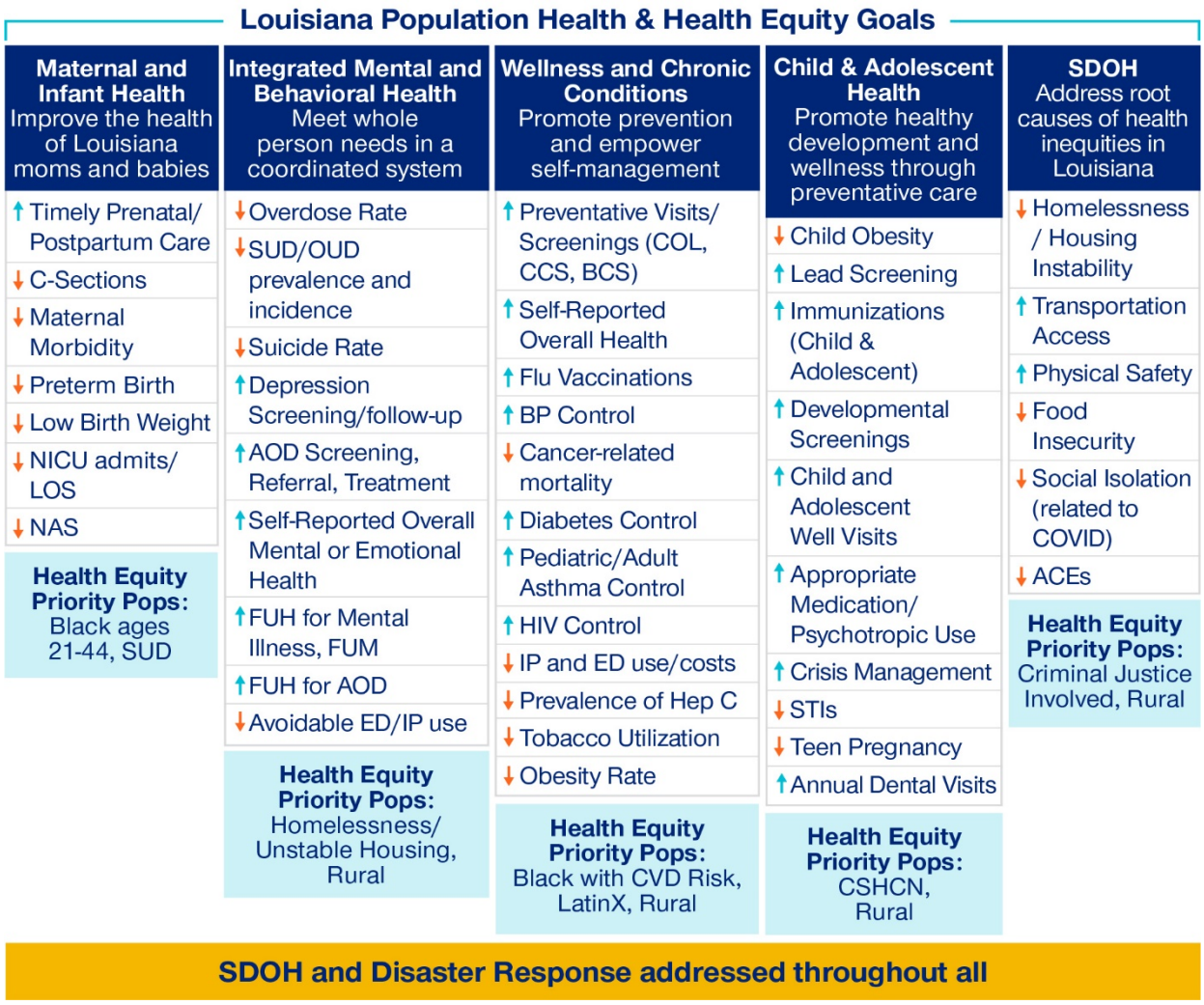

Figure 5. Our population health and health equity goals help us identify and improve disparities to advance health outcomes.

equity for all in Louisiana using the Institute for Healthcare Improvement (IHI) Model for Improvement. **We use data to analyze root causes and key determinants; and engage enrollees thoughtfully, engage provider and community stakeholders in intervention identification,**

design and implementation. We apply the IHI plan-do-study-act (PDSA) method to evaluate outcomes and continuously improve our approaches. Evidence-based practice, innovation, collaboratively addressing root causes, person-centered design, and continuous quality improvement inform and guide our Louisiana managed care program. Our population health and health equity goals align with the LDH Quality Strategy.

We use several improvement strategies to improve performance on the LDH priority measures:

- Provider outreach, data-sharing and pay for performance incentive programs for primary care providers, OB/GYNs and behavioral health practitioners are developed utilizing LDH's Quality Performance Measures (Attachment H) as our foundation. For example, **identification of needed improvement on Comprehensive Diabetes Care Eye Exam and HbA1C testing resulted in an increase of over 14 points and 12 points, respectively, from Measurement Year (MY) 2016 through 2019**
- Enrollee outreach, health promotion and incentive programs
- Healthy First Steps pregnancy education and case management for high-risk women
- Tiered case management for enrollees with chronic conditions or complex care needs, including case managers in high volume inpatient facilities to help coordinate care transitions
- Promotion of telehealth programs to increase access, decrease ED visits, and improve coordination of care between primary care providers and specialists

Specific Strategies

Innovation significantly influences our efforts to align our quality improvement program with the LDH Quality Strategy:

- **LDH Goal: Improve Population Health and Address Health Disparities –** Through our co-location at four statewide Wellness Centers located in Baton Rouge, New Orleans (East and West Bank) and the Houma and Thibodaux area, we will provide resources to assist with SDOH needs (e.g., food, housing), connecting with providers via telehealth, transportation, and information regarding chronic disease management. They will be staffed with local CHWs to address enrollees' needs and connect them with the appropriate care.
- **LDH Goal: Promote Wellness and Prevention –** Through our partnership with the Shreveport Housing and Urban Development, we supported their COVID-19 vaccine events at multiple sites across Caddo Parish. This allowed us to meet enrollees in their homes and communities, providing them with masks and hand sanitizer. In addition to the vaccine events, several clinical consultants of our plan met with PCPs and behavioral health providers across the State to enhance collaboration efforts for our enrollees to enable seamless delivery of care.
- **LDH Goal: Facilitate Patient-centered, Whole-person Integrated Care –** We see Medical Behavioral Integration as essential to whole-person care and focus on building relationships with our providers to understand their patient panel and their capacity to actively engage enrollees in obtaining covered services. To support provider efforts, we deploy 40 provider-facing professionals throughout the State who provide data-driven solutions to medical and behavioral health providers to enhance processes serving our enrollees and increase incentive earning potential.
- **LDH Goal: Improve Coordination and Transition of Care –** We are improving behavioral health provider access through Louisiana-based telehealth services for enrollees in targeted pediatric offices where behavioral health care access has been a challenge. The ability for

high volume pediatric providers to readily access behavioral health treatment for their patients will allow improved performance in post hospital discharge follow up for our enrollees.

2.6.11.2 The Proposer's approach should include:

2.6.11.2.1 A description of the Proposer's assessment (using available data sources) of utilization rates and the…

Monitoring overall utilization (underutilization, overutilization and inappropriate) is a core component of our QAPI and Healthcare Quality and Utilization Committee (HQUM) programs. Combining these with our data resources, we continually identify areas of improvement including creating and revising clinical policies, procedures and processes; educating providers; and implementing enrollee outreach programs to discern service utilization rates.

With both our population health approach and focus on the Triple Aim, our HQUM Committee oversees continuous quality improvement processes to track utilization and compare progress year over year. In support of the LDH Quality Strategy, we focus on wellness and prevention services, readmissions and ED visits, and low value care to create successes in increasing adult flu shot rates for adults and in decreasing ED visits/1,000 enrollees.

LDH Priority Measures	2017	2018	2019	Cumulative Change
Ambulatory Care – Emergency Department Visits/1,000 enrollees	78.36	69.77	71.37	↓6.99 visits/1000 enrollees
Flu Vaccinations for Adults Ages 18 to 64	31.11%	39.41%	41.11%	↑10 percentage points

Using Utilization Management Data to Improve Appropriate Use of Service

Data sources for monitoring, analysis and action planning include:

- **Impact Pro:** This tool provides predictive models and metrics to support effective and equitable care management programs, including assisting in the identification of enrollees with high utilization of services including ED visits with impactable clinical opportunities, such as a gap in evidence-based care like no or intermittent MAT among those with OUD.
- **Hotspotting:** Provides heat maps to track utilization patterns across the State for timely identification within a defined region and for engagement of individual enrollees with high utilization patterns; complex social, behavioral or medical needs, and high costs drilldowns.
- **Drug Utilization Review Reports:** A provider-targeted program that provides retrospective and prospective pharmacy data to minimize the occurrence of drug interaction, age-inappropriate medication use, and inappropriate drug use. It enhances provider awareness of appropriate medication use and promotes duplicate polypharmacy awareness.
- **Patient Care Opportunity Report (PCOR) and Provider Scorecards:** These tools monitor trends at the provider- and practice-level, including metrics tied to overused services such as ED visits and underused services such as preventive care. **Our PCOR, updated and available monthly, on demand, provides useful data for providers.**
- **HealthView Analytics:** This tool makes advanced utilization and outcome analytics readily accessible to our clinical leadership. It provides practical insights to our CMOs and Health Services Directors by depicting how indicators — including avoidable ED use, NICU deliveries, and medication non-adherence — affect subpopulations of our enrollees such as those who

live in a certain parish, identify with a certain race or ethnicity, or who have co-occurring HIV and opioid use disorder.

2.6.11.2.2 A description of incentives that will be implemented for providers and enrollees to incentivize delivery…

UnitedHealthcare continues to evolve our approach to VBP for Louisiana's Medicaid Managed Care providers in support of the Triple Aim. Our goal is to incent both the provider and the enrollee for optimal delivery of care. Implemented since 2015, our provider incentives have continued to expand to include our unique pay-for-performance gap closure model for PCP and OB providers, along with our shared-savings program. Responding to provider feedback, our incentive model was changed in 2018. **LDH assessed all MCO incentive plans and ours was chosen as the model for all plans.**

Monthly, providers can view open gaps in care via the PCOR, which pays based upon each gap closed versus the models that pay providers only when targets are met. Incentives are used to help drive quality and improve enrollee outcomes by focusing on preventive care and chronic conditions, which include maternity, NICU, behavioral health, hospital, specialist, Hepatitis C treatment completion, developmental screenings and COVID-19 vaccination, which covers all five of the preferred LDH models. We are piloting a program to incentivize providers for detection and resolution of SDOH for our enrollees. A sample of the effectiveness of our incentives is demonstrated below, showing the needle moving up the continuum year over year through direct provider education.

Measures	MY2016	MY2017	MY2018	MY2019
Weight Management and Counseling for Nutrition and Physical Activity for Children/Adolescents Body Mass Index Assessment for Children/Adolescents-*BMI Percentile*	60.1%	71.53%	69.83%	80.54%
Adult BMI Assessment	82.75%	85.89%	86.62%	91.97%

Enrollee incentives are available for completion of the Health Needs Assessment (HNA), prenatal and postpartum visits, completion of well child and adult exams, dental services for adults, eye exams to include the ability to purchase frames or contacts, chiropractic services, acupuncture, tobacco cessation, medical respite care for the homeless, yearly well-child visits and newborn circumcision. These benefits are offered through our enrollee services. Case management is available to assist with enrollee-specific needs as they arise. Along with our provider incentives, our enrollee incentives have increased the health of our enrollees as evidenced by our prenatal and postpartum results.

Measures	MY2016	MY2017	MY2018	MY2019
Prenatal and Postpartum Care – Timeliness of Prenatal Care	85.54%	82.24%	85.16%	88.32%
Prenatal and Postpartum Care – Postpartum Care	64.84%	64.48%	71.53%	78.59%

2.6.11.2.3 A description of evidence-based interventions and strategies that will be used to target super-utilizers …

We focus on helping enrollees with persistent high utilization (three or more ED visits per year) and reducing potentially preventable events (PPE). Our strategy for this begins with data and analytics. We use predictive modeling (Impact Pro), Hotspotting, Special Health Care needs reporting and

Historical claims data, HNAs, and referrals to identify enrollees with persistent high utilization, and then coordinate a multifaceted approach to address the PPE:

- **Direct enrollee engagement:** Deploying **our integrated teams of community health workers (CHWs), social workers and case management nurses who live and work in the communities we serve**, we engage enrollee care through case management interventions. We target enrollees with persistent high utilization with outreach calls and community health worker visits to address their specific needs (transportation, childcare, work schedules, access to care including scheduling PCP or specialist visits). Our case management and enrollee services teams use Aunt Bertha and Unite Us, community resources, and referral platforms to make referrals and address SDOH needs. Further, for enrollees with persistent, high utilization, we make sure their needs are met using an array of care management processes, services, supports and specialized programs such as peer supports, recovery response centers and tools to help enrollees actively manage their conditions. For our most challenging situations, we conduct multidisciplinary continuum of care rounds.
- **Provider Support:** Leveraging our over 40 locally based, provider-facing consultants, advocates and network teams who build supportive relationships with physical, dental and behavioral health providers, we work with providers to allow enrollees with persistent high utilization to get priority walk-in appointments and transportation to the PCP or urgent care. We support our providers with information by sharing daily admissions, discharge and transfer (ADT) data via the Audacious Inquiry (AI) platform to our ACO providers. This enables appropriate follow-up engagement (e.g., schedule appointment within seven days of discharge), reducing readmissions or PPEs.
- **Transformational Payment Investment:** In response to the pandemic and local natural disasters, we made a large investment in our providers to increase telehealth options for our enrollees. The increase in local telehealth options resulted in significant reduced ED use among our enrollees with persistent high utilization. These investments built and strengthened existing telehealth options for 15 FQHCs across the State. The expansion of local telehealth services allowed enrollees to continue to see their local providers from the comfort of their home, preventing unnecessary exposure during the pandemic.
- **Developing programs responsive to overall trends:** Actively monitoring our utilization trends, we identify patterns of care across our population and develop programs to address identified needs. **During COVID-19, we observed a sharp decline in utilization of services, especially the ED, by our enrollees with persistent high utilization.** Historically, this would have been a sign of the effectiveness of our enrollee and provider engagement efforts; however, the decline was sudden and correlated with the timing of the pandemic, and we were concerned our enrollees with persistent high utilization may not be getting all the care they needed. **To improve pandemic access to care, we expanded capabilities to overcome barriers to access, with Louisiana-based providers offering after-hours and telehealth services to meet enrollee needs and improve chronic disease management and control.**

2.6.11.3 The Proposer should describe how the Proposer's Medicaid managed care Quality Assessment and …

Our approach to proactively identifying and implementing organizationwide initiatives to improve the health status of our enrollees is based upon the Institute for Healthcare Improvement (IHI) Model for Improvement. Our approach follows a four-step iterative process to identify, assess, design and evaluate our programs and strategies: using data to identify opportunities and analyze root causes

and key determinants; thoughtful engagement of enrollee, provider and community stakeholders in development and implementation of interventions; and applying best practices in quality improvement science, such as the IHI plan-do-study-act (PDSA) method to evaluate outcomes and continuously improve our programs as evidenced by our results in our Hepatitis C Improvement Project that showed improvement by 10 percentage points. Core population health principles of evidence-based practice, health equity, innovation, collaboratively addressing root causes, person-centered design, and a culture of continuous quality improvement inform and guide our Louisiana managed care program.

2.6.11.3.1 Analyzing gaps in delivery of services and gaps in quality of care, areas for improved management of …

Identifying and Defining Measures for Monitoring and Improvement

Our approach begins by establishing our overarching strategic population health goals in support of LDH's Quality Strategy and Triple Aim focus on better care, healthier people and healthier communities with smarter spending. For each of our overarching goals, we monitor relevant, nationally recognized metrics based upon established clinical practice guidelines, such as measures from HEDIS®, CMS, CAHPS® and AHRQ to measure areas such as preventive health, chronic disease management and acute care. We identify key health equity priority populations within each population segment based upon existing data on access to care and health outcome disparities within the State. Recognizing Louisiana has one of the highest rates per capita of HIV infection, as demonstrated below, we were able to improve HIV Viral Load Suppression through provider education and collaboration, which resulted in the highest rate of all MCOs:

Measure	MY2016	MY2017	MY2018	MY2019
HIV Viral Load Suppression	60.46%	75.7%	76.79%	82.59%

Bi-monthly reporting enables us to trend progress over time, tracking against established performance targets. Should these key quality metrics not meet the performance thresholds we set, we analyze data for the identified improvement opportunity using our wide range of analytic tools, such as geo-mapping, to begin the process of defining the performance gap and establishing the quality improvement approach. These proprietary tools synthesize metrics to identify characteristics, trends and needs of the population and identify subpopulations for targeted action.

In this way, our population health quality team, with the oversight of our Quality Management Committee, monitors our ongoing performance on key measures of care and identifies areas requiring targeted or ongoing quality improvement strategies. We continually update our population health strategic goals and health equity priority populations based upon publicly available state data, LDH's Quality Strategy, State Health Improvement Plan and Healthy People 2030 goals, membership population health assessment and analytics, and input from key state and community stakeholders.

Measuring Disparities in Health Outcomes

Advance Health Equity

As we initiate our improvement strategy, advancing health equity and addressing priority SDOH are foundational to our approach. Analyzing the composition of enrollees and the characteristics of those enrollees, we identify subpopulations where disparities in care need to be addressed. With the help of our **SDOH and Health Equity Council**, we think critically about why some populations are healthier than others, and what actions we can take as an MCO, in partnership with LDH and other stakeholders, to achieve more equitable outcomes, both for our enrollees and the broader state population. We use

disparity analyses to compare subpopulations, applying techniques learned through our Multicultural Health Care Distinction efforts, Index of Disparity, and the Area Deprivation Index. We launched our SDOH Pilot incentive program for providers in rural areas throughout the State to increase use of the PRAPARE Screening tool and assist with identification of enrollee needs. Through this program, we close the loop and connect the enrollee with local organizations to assist with food, housing, safety and other possible needs. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool, is a standardized and thorough SDOH screening mechanism used nationally by providers, federally qualified health centers (FQHCs) and social service organizations, allowing us to align screening efforts.

2.6.11.3.2 Identifying underlying reasons for variations in the provision of care to enrollees; and

Identifying Underlying Variations

We recognize there are multi-level factors that affect health (e.g., SDOH, delivery system, community contexts, health behaviors). By performing root cause analyses informed through data analytics, literature review and stakeholder feedback, we quantitatively and qualitatively develop an understanding of the key drivers of care performance and the disparities that occur. Through enrollee, provider and community insights, we validate our analytic findings, further refine our understanding of key determinants, and begin to define actual needs and assets in the community and system of care. Variations are identified by:

Social determinants of health and community factors: Community Health Needs Assessments, County Health Rankings, Area Deprivation Index, State and community input via local relationships, SDOH and Equity Collaborative Council, enrollee SDOH data and state-declared emergency locations during disasters that affect vulnerable populations and magnify disparities

Delivery system factors: Provider-level quality data, integration of medical and behavioral health, length of stay and 30-day readmission data, appointment availability and general access care (especially for specialists and behavioral health providers), provider ability to deliver trauma-informed care, overutilization and underutilization patterns, and access to culturally appropriate care

Enrollee health behaviors: Claims analysis, enrollee surveys, listening sessions and grievances

2.6.11.3.3 Implementing improvement strategies related to analytical findings pursuant to the two (2) functions …

Designing and Deploying Improvement Strategies

Addressing improvement opportunities identified through monitoring key quality indicators, we collaborate with partners to develop and deploy interventions aligned to the root causes or key drivers of performance, with a focus on reducing disparities. **A data-driven clinical initiative that was initiated within the past 24 months** was our Hepatitis C PIP. This topic was chosen by LDH in an attempt to eradicate Hepatitis C from our population. Underlying causes are often complex and multi-faceted and we work with local partners to consider what can be done at multiple levels — community, health system, organizational and enrollee — to reduce disparities and improve the health of the entire community. We use and promote evidence-based programs and practices and incorporate stakeholder input in our intervention design. Our effort to improve screening and initiation of treatment for **chronic Hepatitis C Virus (HCV) by 10 percentage points** demonstrates a clinical initiative following our four-step process:

- **Identify and Define:** HCV prevalence in Louisiana is estimated at 1.6% to 1.8%, with higher rates among people ages 45 to 54, urban residents, and African American males ages 45 to 54 (LA OPH, 2015). Through this identification, Healthy Louisiana enrollees began to have access to safe and effective treatment for Hepatitis C. Baseline measurement indicates an opportunity to improve performance in seven quality measures associated with clinical practice guidelines for HCV screening and treatment, including focused improvement for disparities related to age, geography and race.
- **Assess and Understand:** Based upon LDH feedback, we identified barriers through direct feedback from providers, enrollees, literature review and further data analysis. Specific barriers identified include enrollee lack of awareness of the newly available treatment for HCV, complications accessing treatment due to co-occurring substance use disorder, and concerns about seeking treatment during the COVID-19 pandemic. Additionally, we identified the need for provider education on the clinical guidelines for HCV screening and treatment.
- **Design and Deploy:** We designed improvement strategies based upon guidance from the external quality review organization, feedback from providers and enrollees, and discussions by our internal multidisciplinary team. In alignment with the identified barriers, interventions were deployed through mechanisms such as enhanced case management outreach and provider education on clinical guidelines and data-sharing on practice performance and identification of assigned enrollees in cohorts likely to experience disparate care, including those with comorbid conditions.
- **Evaluate and Evolve:** All performance indicators noted improvement over the year and three of the seven performance indicators either met or exceeded the baseline target rate. With the emergence of COVID-19 creating a barrier for HCV testing, we had to modify our improvement strategy: To encourage enrollees to seek screening and treatment, we disseminated facemasks to local FQHCs for use with enrollees at risk for or with confirmed HCV. The target rates will be adjusted accordingly as we monitor for continuous improvement.

2.6.11.4 The Proposer should submit an overview of its proposed approach to Quality Management and Quality …

2.6.11.4.1 The Proposer's current QM/QI organizational plan description, goals, quality committees, and …

Our current approach to QM/QI builds upon our established Quality Assessment and Performance Improvement (QAPI) program. We follow the LDH Medicaid Quality Strategy that incorporates strategic population health goals tied directly to the Institute for Healthcare Improvement (IHI) Triple Aim: to achieve better health outcomes at lower costs while increasing screening rates and reducing disparities. Success or need for program modification is evidenced by nationally recognized metrics, particularly those prioritized by LDH. Our QAPI program goals are:

- **Ensure** access to care to meet enrollee needs
- **Improve** coordination and transitions of care
- **Facilitate** patient-centered, whole-person care
- **Promote** wellness and prevention
- **Improve** chronic disease management and control
- **Improve** population health and address health disparities
- **Minimize** wasteful spending

As the table demonstrates, our scores regularly exceed Healthy Louisiana and NCQA QC benchmarks:

Sample Metrics	UnitedHealthcare Score MY 2020	Healthy Louisiana or NCQA QC Benchmark
CAHPS Getting Needed Care Quickly	86.81%	83.31% (HL)
CAHPS Coordination of Care	87.50%	84.80% (HL)
Prenatal and Postpartum Care-	79.32%	65.69% (QC)
Ambulatory Care (ER Utilization)	52.21%	58.19% (QC)

Committees

Our Quality Management Committee (QMC) oversees implementation, coordination and integration of all quality improvement activities within our QAPI program. Our QMC integrates structure and oversight, monitoring quality of care and service across the health system, including physical and behavioral health as well as SDOH and health equity programs. Five subcommittees oversee and drive quality, with each subcommittee chair a member of the QMC to coordinate among the subcommittees. This structure delineates clear accountability, with inclusive participation by leaders from all functional areas within our local health plan who address opportunities to improve care and service. The following table outlines our QMC and subcommittees:

Committee	Description of Quality Management Committee and Oversight
Quality Management Committee (QMC) **Co-Chairs: Karl Lirette, CEO, Dr. Julie Morial, CMO**	This decision-making body meets at least quarterly to coordinate and integrate all QM activities for the health plan. QMC membership includes a designated representative from each voting-enrollee department.
Provider Advisory Committee (PAC) **Chair: Dr. Julie Morial**	The PAC is a peer-review committee consisting of medical and behavioral clinicians. Meeting quarterly, they provide feedback on our QAPI program. The PAC reviews reports on credentialing and recredentialing, clinical practice guidelines, accessibility, availability, PIPs, and network cost of health care.
Healthcare Quality and Utilization Management Committee (HQUM) **Chair: Dr. Julie Morial**	The HQUM committee meets quarterly and monitors clinical QI and utilization management program activities for both physical and behavioral care, and monitors and acts on overutilization and underutilization trends.
Service Quality Improvement Subcommittee (SQIS) **Chair: Angela Olden, COO**	The SQIS meets quarterly to monitor the quality of enrollee and provider services and service performance levels. The SQIS oversees delegated service functions.
Member Advisory Committee (MAC) **Chair: Felice Hill, Director of Marketing**	The MAC meets quarterly to seek feedback from participating enrollees and their family enrollees on our population health programs and quality improvement initiatives. The MAC reflects the diversity of our enrollees in race, gender, special populations and geographic areas.
SDOH and Health Equity Council **Chair: Felice Hill, Director of Marketing**	Meeting quarterly, this council brings together community leaders across the State to share information, collaborate, and co-create community-based solutions to address disparities.

Schedule of Quality Activities

QAPI program activities involve scheduled mechanisms to measure and evaluate the total scope of services provided to health plan enrollees, including at a minimum:

Annually: We document our QAPI program through three documents The *QI Program Description* outlines our committee structure, leadership accountabilities, and the core components of the program. *The Quality Program Evaluation* details how we evaluate the efficacy of our QAPI program and verify adherence to LDH's Quality Strategy. Our QMC reviews and approves these documents at least annually. Following approval, we build the *QI Work Plan* to lay out our quality committee meeting agendas.

Quarterly: Our QMC meet at least quarterly to review the applicable components of the work plan, as well as data and status reports on performance improvement activities. Committee activities and decisions maintain the plan throughout the year.

Monthly: The *QI Work Plan* is a living document we revise monthly to reflect interventions and prioritize improvement opportunities. We complete work plan activities within the year and evaluate each component via the program evaluation, with findings incorporated into the next year's work plan, embedding the process of continuous quality improvement into our QAPI program.

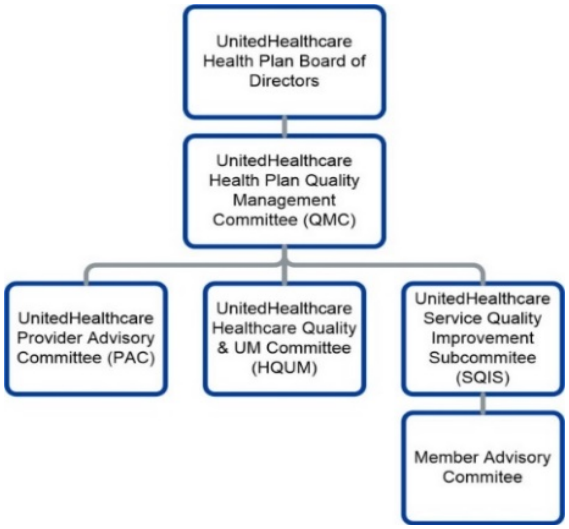

Figure 6. Our QM Committee is structured to improve quality and safety.

Ongoing: Our quality team monitors quality indicators, identifies improvement opportunities, and applies QI methods ranging from *Plan-Do-Study-Act* improvement cycles to formal performance improvement projects. We work directly with our enrollees, providers and other stakeholders throughout the year, incorporating their feedback into our QM/QI approach.

2.6.11.4.2 A description and organizational chart of its proposed QM/QI program, including a list of the …

The QM/QI program monitors, evaluates and improves the quality and safety of clinical care and quality of services. The program is governed through the QM committee structure shown in figure 8.

Quality Management Staffing Resources

Every employee in our health plan helps improve quality of care and service for our enrollees. Led by CEO Karl Lirette, this collective accountability is embedded in all health plan clinical and operations functions. Direct, day-to-day facilitation of our population health-based quality improvement program, our team of clinicians, and quality improvement professionals is overseen by:

Medical Directors (3)

- **Dr. Julie Morial** is a Louisiana licensed physician, board-certified in internal medicine. She is the chairperson of the PAC and is co-chairperson of the QMC.
- **Dr. Jose Calderon-Abbo** is a Louisiana-licensed physician board-certified in psychiatry and addiction medicine. He is responsible for the behavioral health business unit and services. He has oversight of United Behavioral Health, our behavioral health services subcontractor.

- **Dr. Glenda Johnson** is a Louisiana licensed physician, board-certified in obstetrics and gynecology. She is instrumental in all aspects of our business, sharing her knowledge throughout our many programs.

Population Health and Quality Improvement Staff (18)

- **Director Deborah Junot, BSN, RN**, is responsible for the population health-based quality improvement program. She oversees day-to-day program operations, including quality outcomes (e.g., HEDIS), enrollee surveys (CAHPS), and Performance Improvement Projects (PIPs). She represents the health plan at LDH state quality meetings and confirms alignment between our QAPI program and the LDH Medicaid Quality Strategy and oversees a team of **clinicians and quality improvement experts:**

Staff Employed	
Associate Director – 1	Manager – 1
Director of Care Integration – 1	Population Health Consultants – 6
Manager SDOH – 1	Community Liaison – 1
EDSPT Coordinator – 1	Special Projects and Outreach Staff – 3
Administrative Support – 2	Analysts – 2

Provider-facing Outreach and Engagement Staff

Our provider-facing staff includes 40 clinical and non-clinical cross-functional staff with expertise in both medical and behavioral health provider engagement. These staff meet with participating providers to review quality performance, utilization patterns and cost analyses. They educate on available clinical management tools, track provider performance over time in alignment with our value-based payment programs, and support provider-level quality improvement processes.

Praise from Mercy Medical Center

"Working together is an outstanding asset that keeps our health center up to date on all important information that could be missed. It is our hope that we will be able to continue and grow with UnitedHealthcare in the many years to come..."

Lisa Daughtry, CRT, Mercy Medical Quality Department

2.6.11.4.3 The Proposer should demonstrate its capacity to participate in LDH's annual HEDIS® performance …

We report all quality performance measures identified in the contract to LDH annually, using the most current NCQA HEDIS specifications and have reliably participated in LDH's annual performance measurement and reporting initiatives since 2012. Our local knowledge paired with best practices shared across 31 states generate, report and improve HEDIS, CMS Core, AHRQ, and other measure sets in support of LDH's data-driven initiatives. In 2021, for nationwide measurement of care rendered in 2020, we completed 62 Medicaid health plan HEDIS submissions, 76 commercial submissions, four Exchange submissions, six Medicare Medicaid Plan (MMP) submissions, and 201 Medicare submissions. All submissions are deemed reportable by external (NCQA-certified) compliance auditors through validation of our administrative, medical record, and supplemental data collection methods, and reporting algorithms**. Locally, we employ Louisiana-based internal case manager enrollees along with Louisiana-based contractors who are dedicated to the hybrid data collection season. This staff enhances our administrative rates and outcomes, to help us achieve a 99.8% Medicaid retrieval rate.**

2.6.11.4.4 The Proposer should provide an example of a recent successful quality improvement activity; and

Louisiana places 45th in U.S. health rankings in hypertension prevalence. Monitoring against HEDIS® performance targets for Controlling High Blood Pressure, our quality team identified a need to increase the percentage of our enrollees with controlled hypertension. **As a result of our QI process, we improved the percentage of enrollees with uncontrolled hypertension by over 19 points and the Comprehensive Diabetes Care-BP Control measure by over 7 points.**

We accomplished this by partnering with providers throughout the State to implement a "tuck-in" call program in 2020. A concept originally developed to decrease weekend emergency department utilization and readmissions through telephonic outreach to chronically ill enrollees, during a "tuck-in" call, a care coordinator confirms the enrollee's health is stable, they have sufficient medications, and they have no needs that may cause an acute episode. Modifying this best practice, we assisted 65 providers to implement a similar process for enrollees with multiple chronic conditions whose data indicated uncontrolled hypertension and validated they had current enrollee-level data and were educated on our benefits and clinical programs. Our primary care providers found this program **not only offered proactive coordination for enrollees' immediate clinical needs but also increased opportunities to address complex enrollee and family questions and concerns**.

2.6.11.4.5 The Proposer should describe how it will identify quality improvement plans and projects to put …

We identify opportunities for improvement through consistent monitoring of key quality metrics against our targets. We analyze performance with a health equity lens, looking for disparities in care based upon variables such as age, geography, race and ethnicity, or SDOH. When performance does not meet goals, we initiate quality improvement plans or projects ranging from more informal PDSA (rapid cycle initiatives) to more formal Performance Improvement Projects (PIPs).

Aligning with LDH's Quality Strategy, topics for QI plans or projects consider clinical conditions and health service delivery issues with the highest prevalence or incidence among our enrollees, the greatest potential for improving health outcomes, and the overall potential to positively affect the Louisiana Medicaid program. We currently manage QI plans for areas such as: increasing access to and use of EPSDT services, improving primary care medical-behavioral integration, and working with FQHCs to improve outreach to enrollees not engaged with the health care system. We have formal PIPs focused on increasing COVID-19 vaccinations, improving rates of developmental screening, improving rates of Hepatitis C screening and treatment, and improving rates of follow-up and treatment for alcohol and other drug abuse or dependence. Following the COVID-19 pandemic, we are considering multiple QI projects focusing on needs heightened in the public health emergency. After review of the American Health Rankings, we have determined to focus on depression and depression screenings in 2022 and beyond, with our behavioral and medical directors developing a comprehensive, integrated plan to improve outcomes for enrollees diagnosed with depression.

2.6.11.5 The Proposer should submit a list of clinical practice guidelines relevant to the LDH Medicaid …

Evidence-based Clinical Practice Guidelines (CPGs) are the framework for clinical decisions, program design, and monitoring quality of enrollee care. Application and monitoring of performance against CPGs has proven to reduce variation in treatment, resulting in enhanced enrollee care and outcomes. Refer to Attachment 2.6.11.5 for a list of CPGs and Attachment 2.6.11.5 Sample Clinical Practice Guideline – American Academy of Pediatrics Bright Futures Periodicity Schedule.

2.6.11.5.1 The proposed process for adopting and disseminating clinical practice guidelines, in collaboration with …

Development and use of CPGs for physical and behavioral health are based upon the adoption and dissemination guidelines of Federal Code 42 C.F.R. § 438.236. Enrollees' needs, NCQA accreditation, and LDH specific directives drive local CPG topic selection. Specific CPGs are chosen from federal guidelines such as the United States Preventive Service Taskforce and specialty society guidelines such as the American Academy of Pediatrics. Guidelines are reviewed for adoption by the Provider Advisory Committee (PAC), the Quality Management Committee, and our national Medical Technology Assessment Committee. Once formally adopted, CPGs are made available to providers and enrollees via our website, provider and enrollee newsletters, provider toolkits, our *Care Provider Manual,* and *Enrollee Handbook*, prior authorization process and care management outreach, and initial and ongoing education. We participate in the Louisiana Managed Medicaid Association, a collaborative of Louisiana MCOs where MCO chief medical officers convene regularly to discuss care guidelines, leading to socialization among our network providers to align with the guidelines.

2.6.11.5.2 How scientific evidence and the opinions of in-network and out-of-network experts and providers will …

We develop medical policies (including technology assessments) based upon scientific evidence, and in the absence of incontrovertible scientific evidence, we base them on national consensus statements by recognized authorities. **Expert opinion, no matter how well regarded, is not the sole basis for medical policies or clinical and preventive guidelines adopted.**

UnitedHealthcare's national team of physician experts and clinical specialists work with our local clinical team and physicians actively practicing in Louisiana, who all provide feedback via our Louisiana PAC. We adopt evidence-based CPGs from nationally recognized sources, evaluating peer-reviewed literature and routine endorsement or updates to promulgated guidelines such as:

Resources for CPGs Based upon Scientific Evidence
American College of Cardiology/American Heart Association for primary prevention or treatment of cardiovascular disease
American Academy of Pediatrics for pediatric preventive health treatment of disorders (including behavioral health)
American College of Obstetrics and Gynecology for maternal health guidelines and standards of care
American Psychiatric Association for behavioral health clinical practice guidelines
American Academy of Child and Adolescent Psychiatry for pediatric behavioral health disorder guidelines
American Society of Addiction Medicine for substance use disorder and behavioral health crisis care guidelines
Global Initiative for Asthma guidelines for the diagnosis and management of asthma
American Diabetes Association for standards for treatment of type 1 and gestational diabetes; strategies to prevent, delay, manage and reduce complications of type 2
United States Preventive Services Task Force recommendations for primary care practice

In-network Experts and Providers: Seven participating providers comprise our PAC: a pediatrician, an internist, two OB/GYNs, a family physician, an addiction specialist, a psychologist, and a psychiatrist. The PAC reviews, adopts and recommends guidelines, including local clinical practice standards and other considerations.

Out-of-network Experts and Providers: When CPGs are developed internally by UnitedHealthcare's physician experts, the content is sourced to published studies and other references from nationally recognized organizations.

2.6.11.5.3 How the Proposer plans to evaluate providers' adherence to clinical practice standards and …

Our processes for evaluating population and provider CPG adherence comply with NCQA and LDH requirements. Our primary evaluation uses established quality measures aligned with standard clinical practice, including measures from NCQA (HEDIS), CMS, AHRQ and other national measures. With our quality measure reporting engine, tools such as HealthView Analytics, provider scorecards, and the Patient Care Opportunity Report (PCOR), we evaluate at the practice- and provider-level, and through medical record review evaluate care documentation against established guidelines. Our quality department conducts medical records reviews on PCPs per LDH requirements every two years, addressing CPG elements required of providers and reporting to LDH quarterly and implementing provider interventions, as necessary.

We use the findings to develop and modify programs encouraging adherence—in 2018, we changed our value-based care programs to better align with specific CPGs identifying a need for improved adherence, realigning provider incentives with the provision of services recommended in areas such as pediatric preventive care, diabetes care, and behavioral health. We use our ongoing evaluation processes to identify specific practices or providers who data indicate need education and quality improvement support. For example**,** a practice we collaborated with through our shared savings program had steady improvements from 2016 to 2019**: chlamydia screenings increased 12%, Follow-up Care for Children Prescribed ADHD Medication-continuation increased 24%, and for Immunizations for Adolescents, HPV increased 23% over the same time frame.**

2.6.11.5.4 The ongoing evaluation process for updating and revising the Proposer's clinical practice guidelines to …

CPGs from all sources are subject to review, revision and approval. Local guidelines are reviewed every 12 months, or when indicated by new published evidence. Clinical or preventive guideline policy review is every 12 months or as needed. Updated guidelines are dated and reposted on the physician portal, and a CPG is archived when it no longer meets review criteria. Practitioners are notified of these changes via mail, fax or email.

2.6.11.6 The Proposer should submit, as an attachment using the Quality Response Template provided in the …

Our completed NCQA Health Insurance Plan Ratings for 2019–2020 for our Louisiana Health Plan and all our parent organization's Medicaid managed care contracts with full NCQA accreditation can be found in the Quality Response Template, Attachment 2.6.11.6.

2.6.11.7 The Proposer should provide a copy of its certificate of accreditation by the National Committee for …

As evidenced in Attachment 2.6.11.7, we received an Accreditation status of **"Full"** on Jan. 26, 2021, valid until Jan. 26, 2024, for service and clinical quality to meets or exceeds NCQA's exacting requirements for consumer protection and quality improvement — indicating both the rigor of our continuous quality improvement and our dedication to our enrollees. We are committed to providing high-quality health care programs to raise the bar for extraordinary performance while exceeding the expectations of our state partners.

2.6.11.8 Where a Proposer utilizes a material subcontractor to provide behavioral health services, the Proposer ...

We received accreditation status for our behavioral health services on Jan. 26, 2021, valid until Jan. 26, 2024. Our certificate is included as Attachment 2.6.11.8.

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United Healthcare Clinical Practice Guidelines – Louisiana Medicaid Managed Care Program

- 2020 Global Initiative for Asthma (GINA)
- 2019 AHA/ACC/HRS Focused Update of 2014 Guideline for the Management of Patients with Atrial Fibrillation
- Assessment and Treatment of Children and Adolescents with Anxiety Disorders (2020)
- Autism (2014)
- Eating Disorders (2015)
- Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers (2010)
- Reactive Attachment Disorders (2016) Telepsychiatry with Children and Adolescents (2017)
- Telepsychiatry with Children and Adolescents (2017)
- Pharmacological Treatment of Patients with Alcohol Use Disorder (2018)
- Psychiatric Evaluation of Adults (2015); Treatment of Patients with Schizophrenia (2021)
- Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia (2016)
- Psychological Assessment and Evaluation (2020)
- Treatment of Depression Across Three Age Cohorts (2019)
- Treatment of Posttraumatic Stress Disorder (PTSD) in Adults (2017)
- Alcohol Withdrawal Management (2020); Treatment of Opioid Use Disorder (2020)
- Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents (2019)
- National Guidelines for Behavioral Health Crisis Care Toolkit (2020)
- Treatment Improvement Protocol 63: Medications for Opioid Use Disorder (2020 Update)
- Assessment and Management of Patients at Risk for Suicide (2019)
- Major Depressive Disorder (2016); posttraumatic stress disorder (PTSD) (2017)
- Substance Use Disorder (2015)
- 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk
- 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease
- 2015 ACC/AHA/SCAI Focused Update on Primary Percutaneous Coronary Intervention for Patients with ST-Elevation Myocardial Infarction
- 2014 AHA/ACC Guideline for the Mgmt. of Patients with Non-ST-Elevation Acute Coronary Syndromes
- 2018 Cervical Cancer: Screening - Final Recommendation Statement
- AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/ NLA/PCNA Guideline on the Management of Blood Cholesterol (2018)
- 2021 Global Strategy for the Diagnosis, Management and Prevention of COPD
- Treatment of Patients with Alzheimer's Disease and Other Dementias, 2nd edition (2007); Guideline Watch (October 2014)
- 2021 Standards of Medical Care in Diabetes
- 2013 ACC/AHA Guideline for the Management of Heart Failure; 2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure; 2017 ACC/AHA/HFSA Focused Update of the 2013 ACC/AHA Guideline for the Management of Heart Failure
- Guidelines for the Management of Hemophilia, 3rd edition (2020
- AIDS Info: Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV
- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCN A Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults
- National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI) ™2020 VA/DoD Clinical Practice Guideline for the Management of Adult Overweight and Obesity; Bright Futures, 4th

edition, 2017; Guidelines for Health Supervision of Infants, Children, and Adolescents; Promoting Healthy Weight - p. 15

- Guidelines for Perinatal Care, 8th edition, 2017; Society for Maternal-Fetal Medicine (SMFM) Clinical Guidelines
- 2018 Physical Activity Guidelines for Americans, 2nd edition
- 2021 Recommendations for Preventive Pediatric Health Care (BF)
- Recommendations for Primary Care Practice
- The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3); Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock (2016)
- 2012 Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease; 2014 ACC/AHA/AATS/PCNA/SCAI/STS Focused Update of the Guideline for the Diagnosis and Management of Patients with Stable Ischemic Heart Disease
- 2018 Expert Consensus Decision Pathway on Tobacco Cessation Treatment
- 2016 AMA Code of Medical Ethics Section 8.10 Preventing, Identifying and Treating Violence and Abuse

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	●[9] →			★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←		●[10]	→	←		●	→	←		● →
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20] →																												
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		←	● →		★	★	★	★	★	←		● →		
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←		● →	★	★	★
Hepatitis C Virus Infection[31]																													● →		
Cervical Dysplasia[32]																															●
ORAL HEALTH[33]							●[34]	●[34]	★		★	★	★	★	★	★	★														
Fluoride Varnish[35]							←			●		→																			
Fluoride Supplementation[36]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://pediatrics.aappublications.org/content/142/1/e20181218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full)
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://pediatrics.aappublications.org/content/145/1/e20193449).
12. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://pediatrics.aappublications.org/content/145/1/e20193447).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://crafft.org.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://pediatrics.aappublications.org/content/143/1/e20183259).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/newborn-screening/states) establish the criteria for and coverage of newborn screening procedures and programs.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

(continued)

20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://redbook.solutions.aap.org/SS/immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (http://pediatrics.aappublications.org/content/138/1/e20161493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.* Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*
30. Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
32. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
33. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. Perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
35. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening). Once teeth are present, fluoride varnish may be applied to all children every 3 to 6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
36. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in November 2020 and published in March 2021. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL

- Footnote 11 has been updated to read as follows: "Screening should occur per 'Promoting Optimal Development: Identifying Infant and Young Children With Developmental Disorders Through Developmental Surveillance and Screening' (https://pediatrics.aappublications.org/content/145/1/e20193449)."

AUTISM SPECTRUM DISORDER

- Footnote 12 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (https://pediatrics.aappublications.org/content/145/1/e20193447)."

HEPATITIS C VIRUS INFECTION

- Screening for hepatitis C virus infection has been added to occur at least once between the ages of 18 and 79 years (to be consistent with recommendations of the USPSTF and CDC).
- Footnote 31 has been added to read as follows: "All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually."
- Footnotes 31 through 35 have been renumbered as footnotes 32 through 36.

CHANGES MADE IN OCTOBER 2019

MATERNAL DEPRESSION

- Footnote 16 has been updated to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice' (https://pediatrics.aappublications.org/content/143/1/e20183259)."

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: "Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents' (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

ANEMIA

- Footnote 24 has been updated to read as follows: "Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter)."

LEAD

- Footnote 25 has been updated to read as follows: "For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' (http://pediatrics.aappublications.org/content /138/1/e20161493) and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention' (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)."

HRSA
Health Resources & Services Administration
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							Most Recent NCQA Star Rating Summary (Medicaid) Indicate Year:___2019-2020_____			
Number	State	Medicaid "HMO" Plan Name	Medicaid Enrollment in July 2021	NCQA Accreditation	Populations included (e.g., ABD, TANF, Expansion, LTSS)	Benefits provided (e.g., full benefits, behavioral health only, Medicare/ Medicaid integrated)	Overall	Consumer Satisfaction	Prevention	Treatment
2	CA	UnitedHealthcare Community Plan of CA, Inc. dba UnitedHealthcare Community Plan (CA)	23,673	HP Accredited	TANF, CHIP, Expansion, ABD	Full	PDR	2.0	I	I
3	FL	UnitedHealthcare of Florida, Inc dba UnitedHealthcare Community Plan (FL)	309,173	HP Accredited	TANF, Expansion, ABD, LTSS	Full	3.0	3.5	2.5	2.5
4	HI	UnitedHealthcare Insurance Company dba UnitedHealthcare Community Plan (HI)	58,086	Accredited with LTSS Distinction MHC Distinction	TANF, CHIP, LTSS	Full	3.5	3.5	2.5	3.5
6	KS	UnitedHealthcare of the Midwest Inc. dba UnitedHealthcare Community Plan (KS)	165,457	HP Accredited with LTSS Distinction	TANF, CHIP, Expansio, ABD, LTSS	Full	3.5	3.0	2.5	3.0

7	**LA**	UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Community Plan (LA)	499,158	HP Accredited MHC Distinction	TANF, Expansion, ABD	Full	3.5	4.5	3.0	2.5
8	**MD**	UnitedHealthcare of the Mid-Atlantic, Inc. dba UnitedHealthcare Community Plan (MD)	163,399	HP Accredited MHC Distinction	TANF, Expansion	Medical Only	3.5	2.5	3.0	3.0
9	**MI**	UnitedHealthcare Community Plan, Inc. dba UnitedHealthcare Community Plan (MI)	290,601	HP Accredited MHC Distinction	TANF, CHIP, Expansion, ABD	Full	3.5	2.5	3.0	3.5
10	**MO**	UnitedHealthcare of the Midwest, Inc. dba UnitedHealthcare Community Plan (MO)	229,024	HP Accredited	TANF, CHIP	Full	3.0	3.5	1.5	3.0
11	**MS**	UnitedHealthcare of Mississippi, Inc. dba UnitedHealthcare Community Plan (MS)	219,250	HP Accredited MHC Distinction	TANF, CHIP, Expansion, ABD	Full	3.0	3.0	2.0	2.0
13	**NE**	UnitedHealthcare of the Midlands, Inc d/b/a UnitedHealthcare Community Plan (NE)	112,670	HP Accredited	TANF, CHIP, Expansion, ABD	Full	4.0	4.5	3.0	3.5

14	**NJ**	AmeriChoice of New Jersey, Inc. dba UnitedHealthcare Community Plan (NJ)	387,959	HP Accredited with LTSS Distinction	TANF, CHIP, Expansion, ABD, LTSS	Full	3.5	2.5	3.0	3.5
15	**NY**	UnitedHealthcare of New York, Inc. dba UnitedHealthcare Community Plan (NY)	529,910	HP Accredited	TANF, CHIP, Expansion, ABD	Full	3.5	2.5	2.5	3.5
16	**OH**	UnitedHealthcare Community Plan of Ohio, Inc. dba UnitedHealthcare Community Plan (OH)	374,589	HP Accredited MHC Distinction	TANF, Expansion, ABD, MMP	Full	3.5	3.5	2.5	3.0
17	**PA**	UnitedHealthcare of Pennsylvania, Inc. dba UnitedHealthcare Community Plan (PA)	298,420	HP Accredited MHC Distinction	TANF, CHIP, Expansion	Medicaid-Medical Only, CHIP-Full	3.5	2.0	3.5	3.5
18	**RI**	UnitedHealthcare of New England, Inc dba UnitedHealthcare Community Plan (RI)	96,618	HP Accredited	TANF, Expansion, ABD	Full	4.5	3.5	4.0	4.0
19	**TN**	UnitedHealthcare of the River Valley, Inc dba UnitedHealthcare Community Plan (TN)	486,749	HP Accredited with LTSS Distinction MHC Distinction	TANF, CHIP, Expansion, ABD, LTSS	Full	3.5	3.5	2.5	2.5

20		UnitedHealthcare Community Plan of TX, LLC dba UnitedHealthcare Community Plan (TX)		HP Accredited	TANF, CHIP, Expansion, ABD, MMP, LTSS	Full	2.0	0.0	2.5	2.0
21	**TX**	UnitedHealthcare Insurance Company dba UnitedHealthcare Community Plan (TX)	375,970	HP Accredited	TANF, CHIP, Expansion, ABD, MMP, LTSS	Full	2.0	0.0	2.5	2.0
22	**VA**	UnitedHealthcare of the Mid-Atlantic, Inc. dba UnitedHealthcare Community Plan (VA)	176,330	HP Accredited with LTSS Distinction	TANF, CHIP, Expansion, ABD, LTSS	Full	CCC Plus-3.0 Medallion-2.5	CCC Plus- 3.0 Medallion-I	CCC Plus-1.5 Medallion-2.0	CCC Plus-3.0 Medallion-2.5
23	**WA**	UnitedHealthcare of Washington, Inc d/b/a UnitedHealthcare Community Plan, Inc (WA)	248,934	HP Accredited	TANF, CHIP, Expansion, ABD	Full	3.5	2.5	2.5	3.0
24	**WI**	Care Improvement Plus of Wisconsin dba UnitedHealthcare Community Plan (WI)	230,297	HP Accredited	TANF, Expansion, ABD	Full	4.0	3.5	3.5	3.5

I- Insufficient Data, Plan Starting Up

PDR- Partial Data Reported, Plan
Starting Up
NA- Not applicable, plan not operational at time

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Community Plan (LA)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

David Chin, MD
CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

07/07/2020	07/07/2023
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare Community Plan of California dba UnitedHealthcare Community Plan (CA)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

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03/30/2021	03/30/2024
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare of Florida, Inc. dba UnitedHealthcare Community Plan (FL)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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02/06/2019	02/06/2022
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

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UnitedHealthcare Insurance Company dba UnitedHealthcare Community Plan (HI)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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03/08/2021
DATE GRANTED

03/08/2024
EXPIRATION DATE

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National Committee for Quality Assurance

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UnitedHealthcare of the Midwest, Inc. dba UnitedHealthcare Community Plan (KS)

Medicaid HMO

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Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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11/07/2018	**11/07/2021**
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare of the Mid-Atlantic, Inc. dba UnitedHealthcare Community Plan (MD)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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02/08/2021	02/08/2024
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare Community Plan of Michigan, Inc. dba UnitedHealthcare Community Plan (MI)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

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12/31/2019
DATE GRANTED

12/31/2022
EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare of the Midwest, Inc. dba UnitedHealthcare Community Plan (MO)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

05/21/2019	05/21/2022
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare of Mississippi, Inc dba UnitedHealthcare Community Plan (MS CAN)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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02/06/2019	**02/06/2022**
DATE GRANTED	EXPIRATION DATE

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National Committee for Quality Assurance

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UnitedHealthcare of Mississippi, Inc dba UnitedHealthcare Community Plan (MS CHIP)

Medicaid HMO

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Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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02/06/2019	**02/06/2022**
DATE GRANTED	EXPIRATION DATE

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National Committee for Quality Assurance

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UnitedHealthcare of the Midlands, Inc. dba UnitedHealthcare Community Plan (NE)

Medicaid HMO

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Accredited

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CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

08/17/2020	**08/17/2023**
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

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AmeriChoice of New Jersey, Inc. dba UnitedHealthcare Community Plan (NJ)

Medicaid HMO

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Accredited

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04/30/2020	**04/30/2023**
DATE GRANTED	EXPIRATION DATE

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National Committee for Quality Assurance

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UnitedHealthcare of New York, Inc. dba UnitedHealthcare Community Plan (NY)

Medicaid HMO

an accreditation status of

Accredited

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06/08/2021
DATE GRANTED

06/08/2024
EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare Community Plan of Ohio, Inc. dba UnitedHealthcare Community Plan (OH)

Medicaid HMO

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Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

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12/22/2020	12/22/2023
DATE GRANTED	EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare of Pennsylvania, Inc.

Medicaid HMO

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Accredited

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08/28/2019
DATE GRANTED

08/28/2022
EXPIRATION DATE

NCQA
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National Committee for Quality Assurance

has awarded

UnitedHealthcare of New England, Inc.dba UnitedHealthcare Community Plan (RI)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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12/30/2020	12/30/2023
DATE GRANTED	EXPIRATION DATE

NCQA
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Improving health care.

National Committee for Quality Assurance

has awarded

UnitedHealthcare Community Plan of TX, LLC dba UnitedHealthcare Community Plan (TX)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

11/06/2020	**11/06/2023**
DATE GRANTED	EXPIRATION DATE

NCQA
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Improving health care.

National Committee for Quality Assurance

has awarded

UnitedHealthcare Insurance Company dba UnitedHealthcare Community Plan (TX)

Medicaid HMO

an accreditation status of

Accredited

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requirements for consumer protection and quality improvement.

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CHAIR, REVIEW OVERSIGHT COMMITTEE

11/06/2020	11/06/2023
DATE GRANTED	EXPIRATION DATE

NCQA
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Improving health care.

National Committee for Quality Assurance

has awarded

UnitedHealthcare of the Mid-Atlantic dba UnitedHealthcare Community Plan (VA)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

06/22/2020	06/22/2023
DATE GRANTED	EXPIRATION DATE

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

UnitedHealthcare of Washington, Inc. dba UnitedHealthcare Community Plan (WA)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

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Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

08/30/2019
DATE GRANTED

08/08/2021
EXPIRATION DATE

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

UnitedHealthcare of Wisconsin, Inc. dba UnitedHealthcare Community Plan (WI)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

02/11/2020	**02/11/2023**
DATE GRANTED	EXPIRATION DATE

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

United Behavioral Health dba Optum

Medicaid MBHO

the status of

Full

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION FULL

for the development and maintenance of a clinically effective

managed behavioral healthcare delivery system

which maintains as its primary objective the delivery of

high quality member care and service.

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

01/26/2021	01/26/2024
DATE GRANTED	EXPIRATION DATE

2.6.12 Value-Based Payment [10-page limit]

2.6.12.1 The Proposer should propose a Value-Based Payment (VBP) strategic plan, including an implementation …

Support Provider Transformation

Since 2015, we have offered Louisiana providers Value-based Payment (VBP) models and supported them with tools and resources to drive practice transformation and success. This includes consultation, data and technology via our Louisiana clinical consultants and regional provider advocates, who bring proven processes and best practices along with a robust suite of data, reporting and new technology to guide providers' efforts. Our programs support and reward providers for adopting processes that increase access, drive quality improvements, and prepare them to take on risk and evolve up the Alternative Payment Method (APM) risk continuum.

We will partner with LDH and other MCO's to help evolve and advance VBP strategies to further drive quality and efficiency and improve health equity. Our VBP models support all provider types, including the LDH five preferred models.

With providers at varying levels of transformation readiness — and Louisiana's diverse regional health challenges — we meet providers where they are, matching VBP models to their capacity, capabilities, financial and clinical readiness, and population needs. Our suite of programs aligns to the Health Care Payment Learning and Action (HCP-LAN) APM framework and the Triple Aim to improve patient experience and outcomes and reduce costs.

Our local leadership team is led by Karl Lirette, CEO and Angela Olden, COO. Supported by our national VBP team, they guide local quality, provider services, medical economics, and data analytics teams to support VBP. They evaluate providers' readiness to participate in VBP and support them with the data, process improvement, clinical guidance, and tools to proactively manage population health, improve care quality and progress along the VBP continuum.

Figure 1. Our *Create, Collaborate, Connect* approach helps develop VBP programs to fit the needs and readiness of our providers.

Value-based Payment Strategic Plan

As an incumbent MCO and trusted LDH partner, we have collaborated with thousands of providers on VBP since 2015. [redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted] Support Provider Transformation
- [redacted]
- [redacted]
- [redacted]

Alignment to LDH Preferred Models and HCP-LAN APM Framework

The strategic approach above informs the models we deploy for Louisiana providers, focusing on driving quality and health equity improvements that lead to improved enrollee outcomes. The map

shows how we will advance and expand VBP throughout the contract. Examples of current models are outlined below, followed by goals and new models we plan to implement.

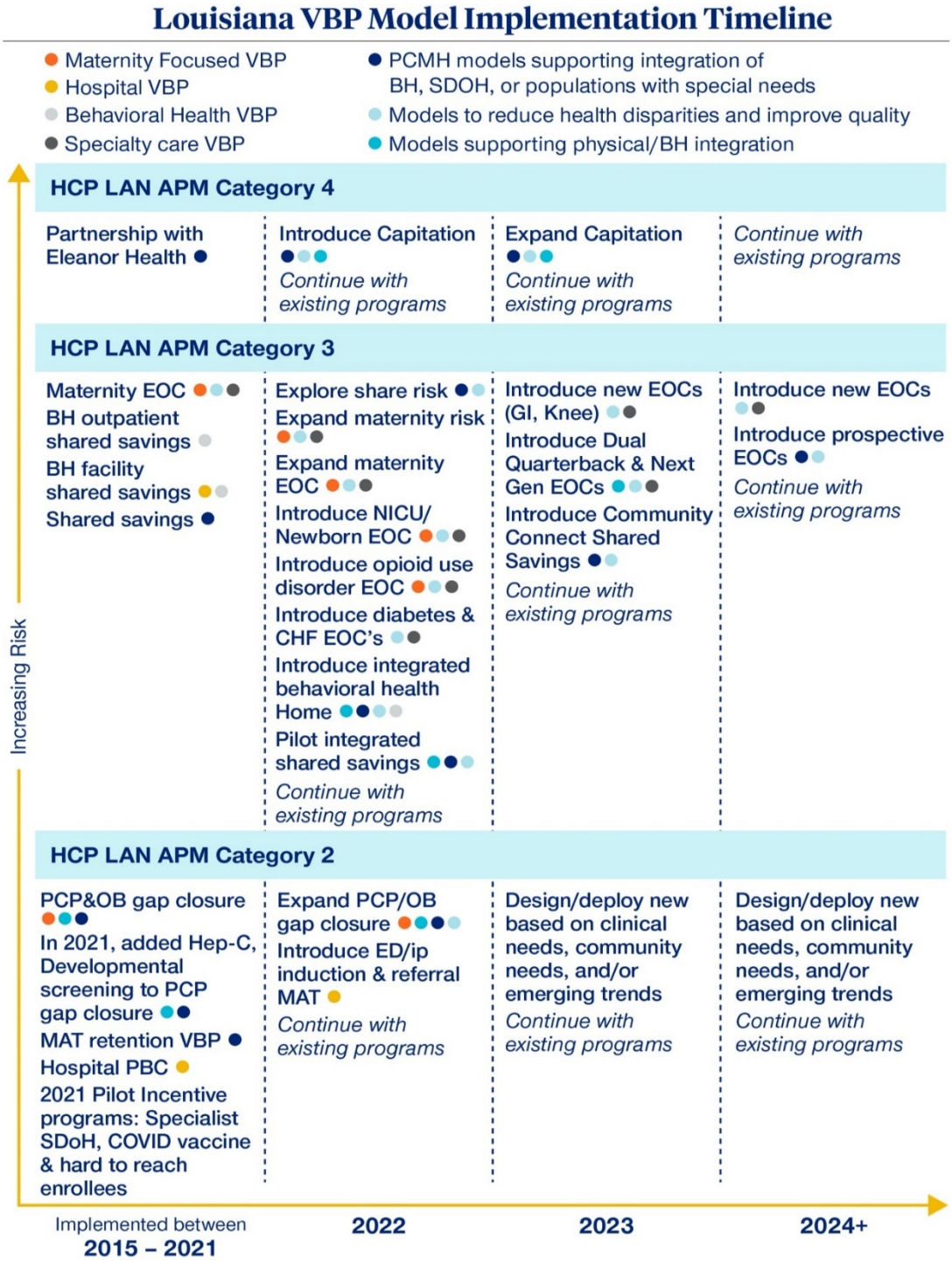


Figure 2. Our Louisiana VBP Model Implementation Timeline maps out UnitedHealthcare's expansion and advancement.

Maternity-focused VBP Arrangements

Implemented in 2018, [redacted]

[redacted]

Supporting Physical and Behavioral Health Integration

Elevate Integrated Care

[redacted]

[redacted]

"Metropolitan Human Services District partnership during this past year has been tremendously valuable to center our focus and improvements around key performance areas that are national standards for high quality of care"

[redacted]

Supporting Providers in Public Health Emergencies (PHE)

Investment in Action
Morehouse Community Medical Center (an FQHC) used the clinical pathway investment funds to purchase a mobile unit to expand COVID-19 testing capacity in rural communities.

Our VBP strategic plan remains flexible and able to adapt, respond and implement new programs based on emerging needs. During the COVID-19 pandemic, we **expedited over $8.6 million in payments for our Gap Closure Incentive program to 572 participating provider groups and proactively paid them 100% of what they earned during 2019.**

To address decreased cash flow at FQHCs and the need to invest in capacity-building efforts due to this historic shift in utilization, we quickly deployed our Clinical Pathways Transformation program, investing over $1.9 million in 19 Louisiana FQHCs to respond to the immediate needs of the pandemic.

2.6.12.2 The strategy should also indicate how the Proposer plans to expand or further enhance these initial …

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

2.6.12.3 The Proposer should include its specific goals for VBP over the life of the contract. Such goals should …

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]	[redacted]
	[redacted]
[redacted]	[redacted]

2.6.12.3.1 The specific models and VBP arrangements the Proposer will implement to ensure that it meets the …

Based on our Louisiana successes, we expect to exceed provider payment requirements for the contract years by deploying new and expanding existing VBP models. Our highly flexible models tie incentives to performance without requiring perfection to unlock earnings — gap closure quality incentives do not penalize providers for gaps left open, and shared savings models allow providers to earn a portion of their allocated savings based upon volume of quality targets achieved. Engaged providers are then well-positioned to earn all incentives outlined in the model they participate in. We will continue to support providers with data, tools and technical assistance to drive quality and outcomes, promote integration and increase enrollee satisfaction while reducing costs. We will deploy new models aligned with LDH-preferred VBP programs listed in Section 2.17.6.1 of the model contract and models for other provider types to exceed required VBP thresholds each year.

[redacted]

Maternity-focused VBP Arrangements

[redacted]

Models Supporting Physical and Behavioral Health Integration

Elevate Integrated Care

[redacted]

Integrated Shared Savings [redacted]

Integrated Behavioral Health Home [redacted]

[redacted]

Professional capitation

[redacted]

Advance Health Equity

[redacted]

Incentives for Specialty Care Providers

[redacted]

dual quarterback **next generation episode models.**

[redacted]

[redacted]

prospective episode payment models [redacted]

2.6.12.3.2 The quantitative, measurable, clinical outcomes the Proposer seeks to improve through implementation …

Quantitative, Measurable, Clinical Outcomes for Improvement

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

2.6.12.3.3 How the Proposer proposes to expand VBP arrangements over the initial years of the contract, and …

Preferred VBP Models Proposed for Implementation

As outlined above, we will continue to expand VBP, focusing on LDH preferred models by identifying new providers not in VBP programs, moving providers as appropriate up the risk continuum by targeting strong performers based upon analytics and our support consultant feedback, and adding new VBP models in the first three years. Our VBP programs align to LDH models:

- **Maternity:** OB Gap Closure, Maternity EOCs
- **Models supporting physical and behavioral health integration:** Gap Closure, Integrated Shared Savings, Integrated Behavioral Health Home
- **PCMH models supporting integration of behavioral health, SDOH and populations with SHCN:** PCP Gap Closure, Shared Savings/Risk, Integrated Shared Savings, Eleanor Health
- **Hospital VBPs:** HPBC, ED/IP MAT Initiation and Referral, BH Facility Shared Savings
- **Other models designed to reduce disparities and improve equity:** Gap Closure, Community Connect Shared Savings Program

2.6.12.3.4 How the Proposer will support providers in successful delivery system reform through these payment …

[redacted]

Support Provider Transformation

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

2.6.13 Claims Management and Systems and Technical Requirements [10-page limit; data flows and charts are excluded from section-specific and …

2.6.13.1 The Proposer should describe how it will customize a Louisiana Medicaid specific system for …

We benefit from the national capabilities of UnitedHealth Group to adapt to a continuously changing market environment. We deliver our approach in a tailored manner at the local market level to support effective care management, strong regulatory partnerships, greater administrative efficiency and improved clinical outcomes.

Achieve Operational Excellence

Exceptional MIS Capability
Over the past two years, our MIS platform achieved:

- Availability rate of 99.992%
- Claims per month – 13.4 million
- Payments per month – $2.4 billion

Since becoming a partner to LDH nine years ago, we have continued to listen and fine tune our approach to help LDH meet its goals. UnitedHealthcare has proven our ability to customize a Louisiana Medicaid system for adjudicating Louisiana Medicaid claims, applicable State administrative rules and statutes.

Our approach has grown and developed alongside the managed Medicaid program itself — our initial deployment as a Shared Savings plan in 2012 required absolute encounter compliance to facilitate our providers' claims being paid. In preparation for our transition to a full-risk MCO in 2015, we specifically configured our claims processing system based upon claim and encounter requirements learned from our previous shared contract. The current system pays more than **$80 million Louisiana Medicaid claims each month**.

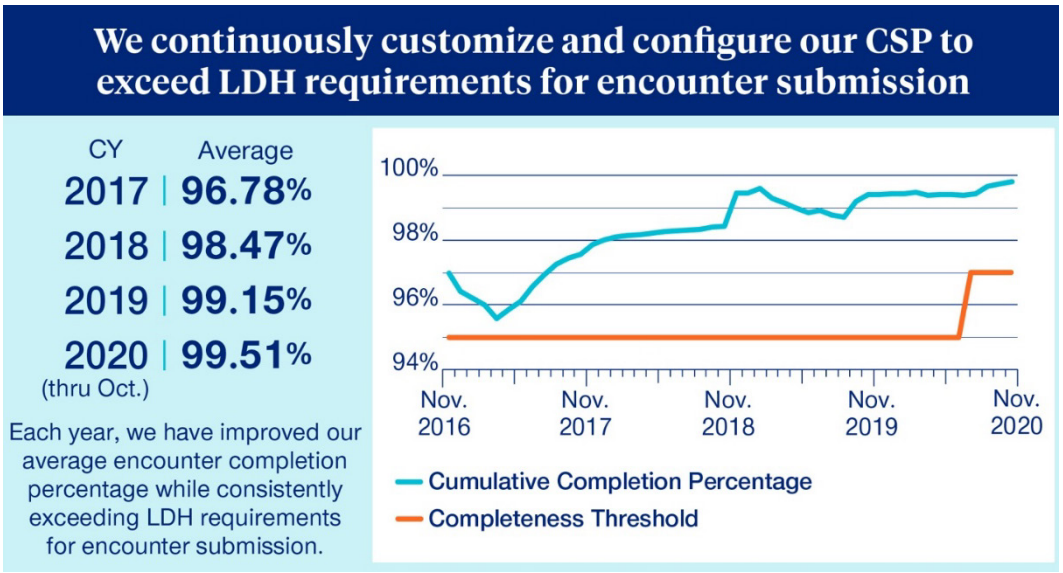


Figure 3. 2016-2020 encounter completion rates consistently exceeded LDH requirements (Source: CY average calculated from monthly rates in Myers & Stauffer January 2019 and January 2021 reports)

We will continue to support Louisiana on our common shared CSP platform. To make certain the Louisiana-specific configuration of our system remains intact, we are implementing process controls and dual check points to prevent automated UnitedHealthcare national policy updates that conflict with Louisiana requirements. Doing this not only safeguards our configuration, but also prevents

provider abrasion over system changes, increasing their satisfaction with the system. Local leaders will have the opportunity to access the national updates, and initiate implementation via the Louisiana Act 319 proactive notification process.

2.6.13.2 The Proposer should describe in detail the Management Information System (MIS) it proposes to use …

Systems Overview

We maintain an integrated management information system (MIS). Shared across our national Medicaid, D-SNP, and ACA Individual Exchange programs and customers, this advanced, scalable platform integrates physical and behavioral health, pharmacy and social service support in full compliance with applicable state and federal regulations. Today, our shared platform supports 31 states with 7,000 concurrent users and more than 7 million enrollees and adjudicates more than 500,000 claims every day. Our shared platform drives economies of scale in both staff and infrastructure, enabling our core systems to stay current and maintained.

Our platform supports day-to-day management of our key operations. It promotes efficient and effective delivery of health care services to Healthy Louisiana enrollees and ease-of-use for network providers. Our scalable platform captures, stores, and effectively uses data received from state agencies, providers, subcontractors and enrollees in compliance with the State's requirements.

Key Features of Our Managed Care Information System

- Unified, comprehensive service delivery system that provides the full array of Healthy Louisiana benefits and services
- Shared, integrated technology platform coordinates benefits and simplifies administration of Medicaid, D-SNP and ACA Individual Exchange programs across the United States
- Integrated clinical platform synchronizes multiple health care management data points and delivers personalized health management solutions that manage care and reduce costs while maintaining enrollee benefits
- Integrated with EVV vendors to support Medicaid populations in 14 states
- System availability rate of 99.992%

At the center of our MIS architecture is Community Strategic Platform (CSP), our TriZetto Facets enrollment and claims administration platform. Using the latest Oracle Exadata database technology, CSP includes interfaces that optimize exchange of information with other key systems. The Oracle Exadata platform is the latest, most advanced hardware for managing database loads, providing for the fastest in-memory databases with redundant hardware and the fastest failure recovery times available. CSP is co-resident on the Exadata platform with our Strategic Management Analytic Reporting Tool (SMART) data-mart and our National Encounter Management Information System (NEMIS) encounters reporting system, improving data freshness for key reporting needs from a day or weeks to as immediate as real time.

Our systems architecture accommodates scalable expansion, allowing us to quickly introduce routine upgrades while providing the latitude for us to plan for increases in computing needs without risk or material operational impact. We run incremental backups daily and full backups weekly, and we implement global best practices for off-site storage and remote backup requirements.

Our System Diagram (provided in our response to 2.6.13.2.3 and 2.6.13.2.4) presents a high-level view of the components of our MIS and the interconnectivity and data exchange with the State. Key MIS components are grouped on the System Diagram by capability domain (enrollee, provider, claims, care management).

2.6.13.2.1 The length of time the Proposer has been utilizing the MIS proposed for the contract; if for fewer than ...
2.6.13.2.2 Hardware and system architecture specifications for all systems that would be used to support the …

Our CSP-based MIS has been successfully serving our Healthy Louisiana enrollees and providers since 2015, but many components of our environment have supported LDH across our longstanding relationship. A complete overview of our IT ecosystem chart for Louisiana, including hardware and system architecture specifications and length of time used for all systems used to support the program, is below.

Healthy Louisiana IT Ecosystem Chart

Systems Purpose / Overview	Name of Application(s)	Used in UnitedHealthcare Medicaid	Name of DB	Operating Hardware Vendor	Operating System Model Series ID	Operating System Vendor
Maintenance of enrollee eligibility/ enrollment and other information, both current and historical	**CSP Facets:** Integrated managed care information system built on the Cognizant Facets platform, which meets all applicable state and federal laws and privacy regulations including, but not limited to, HIPAA. Facets has a comprehensive enrollee database, using unique ID numbers, including eligibility begin and end dates; age-specific information; benefits; enrollment history; enrollee TPL coverage and utilization and expenditure information.	Six years	Oracle	Oracle	Oracle Linux	Oracle
	EEMS: Enhanced enrollment file processing module for CSP allows near real-time system updates, configurable mapping and business rules to increase efficiency and accuracy of the enrollment process, increases speed-to-market for format changes, reduces maintenance costs and improves end-to-end cycle time for loading eligibility.	Two years	Mongo DB	United-Healthcare Cloud Managed Services	OpenShift Kubernetes	Red Hat
	Consumer Database (CDB) and Consumer 360 (C360): Consolidated enrollee database to identify the source of	Over nine years	BD2	IBM	z/OS	IBM

	record and provide search services for basic demographics, benefit types and eligibility spans. The C360 stores indexes to various data types across our systems, enabling a responsive, enrollee-centric, multisystem view for customer service. The CSP transmits eligibility changes to CDB nightly.					
	UnitedHealthcare Mobile: The free, secure UnitedHealthcare enrollee mobile app provides personalized care notifications, medication management capabilities, common administrative transactions similar to myuhc.com, and connects users directly with an enrollee service advocate.	Two years	Postgres 10	Consumer Mobile phones and Tablets	N/A	iOS and Android
	myuhc.com: Secure health and wellness information is available 24 hours a day, seven days a week through our enrollee portal. Enrollees register for online access by setting up a secure HealthSafe ID™ and password. The personalized and easy-to-navigate digital experience allows enrollees to search for covered benefits, manage personal preferences, update contact information (including email addresses), view/print and request we mail an ID card, change their PCP and locate providers through a searchable Provider Directory. The portal offers personalized health and wellness content such as seasonal reminders (e.g., flu shots), personalized care recommendations, links to plan programs, and links to online resources and tools. Content is available in multiple	Over nine years	DB2 MS SQL Server	DB2 - IBM MYSQL - Redhat	DB2-AIX	IBM

	languages and compliant with Web Content Accessibility Guidelines.					
Maintenance of claims information, and/or encounter information for providers with whom the MCO has a capitated arrangement, both current and historical	**CSP Facets:** Integrated managed care information system built on the Cognizant Facets platform. The system's primary functions include benefits, enrollment and disenrollment management, claims pricing, adjudication and payment. The integrated claim processing suite includes claim edits, COB processing, rules-based correction/adjustment, voiding and resubmission, records claim status and payment timeliness data.	Six years	Oracle	Oracle	Oracle Linux	Oracle
	National Encounter Management Information System (NEMIS): Internally developed encounter data submission and reporting system initiates submission of encounters, tracks responses, provides error correction and resubmission of Medicaid encounters in formats specified by our customers.	Over nine years	Oracle	Linux	Oracle Linux	Oracle
Maintenance of authorization and care coordination information, both current and historical	**Integrated Clinical User Experience (ICUE):** This tool enables care coordination, medication management, and quality management by giving providers updated and shared access to enrollees' plan of care or PCSP and supports alignment of clinical problems, goals and interventions. It provides electronic access for the care team, enrollees, caregivers and others, as permitted by the enrollee. Containing claims and authorization data, it includes our Population Registry and gives providers and care communities a comprehensive view of the services used	Over nine years	Oracle, My SQL	Oracle, MySQL	Oracle Linux	Oracle Percona

	by the care population so providers have the clinical history of the whole person. Furthermore, ICUE enables and delivers a coordinated, integrated utilization management experience for our enrollees and the health care communities that support them.					
	CommunityCare: This tool enables care coordination, medication management and quality management by giving care managers and providers updated and shared access to enrollees' care plan and supports alignment of clinical problems, goals and interventions. It provides electronic access for the care team, primary care coordinators, providers, specialists, enrollees, caregivers and others, as permitted by the enrollee. Containing claims information from CSP, authorization data from ICUE, and pharmacy data from OptumRx, CommunityCare includes our Population Registry and gives providers and care communities a comprehensive view of the services used by any given care population. Using the enrollee view within the Population Registry, providers have the clinical history of the whole person. CommunityCare provides automated notifications of care transitions, supports DIRECT for secure clinical data exchange with providers and HIEs, and supports import, parsing and attachment of C-CDA, ADT, LOINC and other standard formats.	Seven years	SQl Server	Altruista	Cisco	Microsoft
	Inovalon QSI-XL™: QSI-XL is a web-based NCQA/HEDIS®-certified quality	Two years	N/A	Inovalon	N/A	N/A

	metrics data processing platform which is used to generate rates for HEDIS® and custom quality metrics. UnitedHealthcare pushes Claims, Rx, Enrollment, enrollee, Provider, Lab, and Supplemental data to QSI-XL on a regular, periodic basis to calculate results for HEDIS® and custom measures.					
	eVisor/Impact Pro: As a component of eSync, eVisor synchronizes claims data with evidence-based medicine guidelines to identify engagement opportunities. Impact Pro is a key analytical engine within the eVisor analytics platform that supports multidimensional, episode-based predictive modeling and care management analytics. It enables our nurse care managers to use clinical, risk and administrative profile information to provide targeted health care service to enrollees. Impact Pro identifies individuals who have not obtained appropriate preventive care and screening and who are at risk for developing costly and debilitating health conditions. It provides enrollee risk stratification and scoring to target specific populations or individuals for different levels of care management intensity managed through ICUE.	Over nine years	MS SQL Server	HP	Windows Server	MS
Maintenance of provider network and other information	**CSP Facets:** Integrated managed care information system built on the Cognizant Facets platform, which meets all applicable state and federal laws and privacy regulations including, but not limited to, HIPAA. Facets has a	Six years	Oracle	Oracle	Oracle Linux	Oracle

	comprehensive provider database, housing Medicaid provider number and NPI, demographics, contracting and credentialing status, affiliations, specialties and types. All enrollee claims and authorizations and clinical service management processing (where a provider reference is required) are linked back to that unique provider record. Provider relationships for enrollees (e.g., Health Home and PCPs) are maintained in Facets.					
	Network Database (NDB): Our provider data is managed in a single enterprise repository of all information related to our provider demographics and networks. NDB sends information nightly to CSP and to our elastic search capabilities.	Over nine years	DB2	IBM	z/OS	IBM
	NetworX: Our Facets NetworX subsystem supports rules-based provider contract configuration and claim pricing.	Six years	Oracle	Microsoft	n/a	OpenSource
Maintenance of information related to enrollee health status and outcomes	**ICUE:** This tool enables care coordination, medication management, and quality management by giving providers updated and shared access to enrollees' plan of care or PCSP and supports alignment of clinical problems, goals and interventions. Containing claims and authorization data, includes our Population Registry and gives providers and care communities a comprehensive view of the services used by the care population so providers have the clinical history of the whole person.	Over nine years	Oracle, My SQL	Oracle, MySQL	Oracle Linux	Oracle Percona
	Inovalon QSI-XL™: QSI-XL is a web-based NCQA/HEDIS®-certified quality	Two years	N/A	Inovalon	N/A	N/A

	metrics data processing platform that is used to generate rates for HEDIS® and custom quality metrics. UnitedHealthcare pushes Claims, Rx, Enrollment, enrollee, Provider, Lab and Supplemental data to QSI-XL on a regular, periodic basis to calculate results for HEDIS® and custom measures.					
	eVisor/Impact Pro: As a component of eSync, eVisor synchronizes claims data with evidence-based medicine guidelines to identify engagement opportunities. Impact Pro is a key analytical engine within the eVisor analytics platform that supports multidimensional, episode-based predictive modeling and care management analytics. It provides enrollee risk stratification and scoring to target specific populations or individuals for different levels of care management intensity managed through ICUE.	Over nine years	MS SQL Server	HP	Windows Server	MS
Maintenance of MCO financial data	**Fin360:** Manages financial transactions to our general ledger and reserving process.	Four years	SAS Storage Utilizing IBM, GFS	IBM	Red Hat Enterprise Linux	HP
	UDW: Financial data warehouse provides consistency and quality of financial tags in analytic financial tools.	Over nine years	Teradata	Teradata	SuSE Linux	Teradata
	Financial Tagging Service (FTS): Financial data tagging system.	Over nine years	MySQL	VMWare	Red Hat Enterprise Linux	IBM
	PeopleSoft: Enterprise financial management solution contains several modules, such as general ledger, asset management, purchasing, accounts payable and accounts receivables, to	Over nine years	Oracle	HP	Red Hat Enterprise Linux	IBM

	provide a consolidated view of financial data.					
Maintenance of information related to enrollee grievance (synonymous with "complaint"), adverse benefit determination appeal, and Maintenance of information related to Provider Complaints and Appeals	**ETS:** Facilitates administration and escalation management and processing of grievances, i.e., complaint. It manages, provides status, triggers letters and tracks resolution on submitted grievances against policy-mandated time frames for enrollee contact and grievance resolution. The application provides flexibility to easily customize data elements according to State needs.	Over nine years	MS SQL Server	HP	Windows Server	Microsoft
Maintenance of internal operations data, e.g., call center statistics and system availability	**Service Now (Optum):** Comprehensive tool supports our UnitedHealthcare Support Center and information technology service management processes, including system monitoring and reporting of critical incidents.	Six years	N/A (Database is externally hosted)	ServiceNow	N/A (Externally hosted by ServiceNow Vendor)	N/A (Externally hosted by ServiceNow Vendor)
	IVR system and Avaya Dialer handle basic enrollee inquiries and direct incoming calls to the most appropriate enrollee services center professional.	Six years	MS SQL Server	Linux, Oracle, Tomcat	Linux	Linux
	Avaya/Qfiniti – Qfiniti Enterprise: The Qfiniti desktop provides call recording and quality monitoring, for evaluating and reporting phone calls through our customer service centers.	Six years	MS SQL	HP	Windows Server	Microsoft

Maintenance of information related to reported incidents that may have compromised patient safety	**QCare:** Incident management system enables us to report critical events or incidents. QCare facilitates tracking and resolving quality of care concerns across all lines of business.	Over nine years	SQL	Microsoft	Windows Server	Microsoft
Generation of the reports stipulated in the contract	**Strategic Management Analytic Reporting Tool (SMART):** SMART is a comprehensive, integrated analytical data warehouse, using the latest Oracle Exadata Database platform that holds all Medicaid relevant information — including claims data (e.g., medical, pharmacy, vision and lab), enrollee data, provider data, authorizations, subcontractor data and predictive modeling information.	Over nine years	Oracle	Oracle	Oracle Linux	Oracle
Processing of claims including electronic submission and, where applicable, automated and/or rules-based adjudication	**CSP Facets:** Integrated managed care information system built on the Cognizant Facets platform, which meets all applicable state and federal laws and privacy regulations including, but not limited to, HIPAA. Facets has a comprehensive enrollee database, using unique ID numbers, including eligibility begin and end dates; age-specific information; benefits; enrollment history; enrollee TPL coverage and utilization and expenditure information.	Six years	Oracle	Oracle	Oracle Linux	Oracle
	Claims Rule Engine (CRE): CRE enables claim edits based upon configurable business rules that are quick to modify and deploy. Edits range from provider validation to CPT code-based rules.	Four years	MySQL	IBM	z/OS	IBM

	ODAR: Online Downadjust Audit Recovery	Six years	SQL Server	Microsoft Virtual Machine	Windows Server	Microsoft
	Optum Clearinghouse and CPE: We use this multipayer electronic data interchange (EDI) clearinghouse for electronic claims submissions. The clearinghouse and CPE provide a common entry point and orchestration/routing system for claims within UnitedHealthcare, managing common storage and common capabilities pre- and post-adjudication processes.	Over nine years	MySQL	CISCO	Red Hat Enterprise Linux	Red Hat
	Managed Gateway (MGD) and Optum Transaction Validation Manager (OTVM): Provide EDI validation that tests and certifies HIPAA transaction sets and verifies compliance with standards and regulations on inbound claims. MGD serves as a full-scale delivery model made up of connectivity, technology and dedicated services; it is the exclusive Payer EDI transaction intake focused on receipt, editing and delivery of EDI transactions per Payer defined processes and guidelines. Facilitates HIPAA connection and submission compliance on behalf of the Payer.	Over nine years	Oracle	Oracle	Red Hat Enterprise Linux	Oracle
	HIPAA Gateway: Provides final HIPAA validation edits, market-specific custom claims edits and claim transformation, on load of claims to CSP Facets.	Six years	Oracle	Oracle	Oracle Linux	Oracle
	Doc360: Based upon Documentum, Doc360 provides the capability to store, view and retrieve paper documents	Three years	MySQL and Postgres	VMWare	Red Hat Enterprise Linux	Red Hat

	mailed to us, including clinical material, claims, letters and other attachments. Doc360 is accessible from our applications either via application programming interface (API) or a web client.					
	MACESS: Workflow application facilitates claim processing — including viewing of paper claims and supporting documentation in Doc360 — routing of claims to our claim processors and issues to our appeals and grievances team.	Six years	MS SQL Server	HP	Windows Server	Microsoft
	Care Provider Early Warning System (CP-EWS): Scans for unusual patterns in claims receipts, denials, rejections, and cash paid at the State and provider level, allowing early intervention, outreach and education to our provider community.	Two years	Oracle	Oracle		
	NetworX: Our Facets NetworX subsystem supports rules-based provider contract configuration and claim pricing.	Six years	Oracle	Oracle VWWARE	Windows Server	Microsoft
	OptumInsight Claim Edit System (CES): Clinical claim editing system analyzes provider health care claims based upon business rules to automate reimbursement policy and industry standard coding practices.	Over nine years	Oracle	Oracle	Red Hat Enterprise Linux	Red Hat
	Prospective 2.0: Tool with proprietary algorithms identifies fraud and abuse prior to claims payment allowing a greater recovery than post-payment.	Over nine years	Oracle	Oracle	Oracle Linux	Oracle
	Smart Audit Master (SAM): Claim's payment validation tool screens for the most common errors.	Over nine years	MS SQL	Microsoft	N/A	Microsoft

	Advanced Claims Editing (ACE): ACE flags claims with potential errors/edits in the pre-adjudication workflow, prior to the formal claims adjudication process. ACE scans electronic data interchange (EDI) claims and returns electronic messages back to the submitting provider's office — enabling the submitter to fix issues before adjudication.	Two years	Oracle	Oracle	Red Hat Enterprise Linux	Red Hat
	Sophia or Community and State Virtual Assistant (CS ChatBot): We manage and maintain the standard operating instructions for claim processing. We automate steps within the instructions, if possible. Claim processors receive step by step instructions for processing claims that are pended for manual review.	Two years	PostgresDB, MongoDB, Redis	VMWare	Red Hat Enterprise Linux	Red Hat
	Web.Strat: Calculates reimbursement for claims and ambulatory procedural classifications (APCs).	Over nine years	SQL Server	Microsoft	Windows	Windows
Processing of transactions between the MCO and its enrollees and between the MCO and providers, including, but not limited to, provider applications for network participation, enrollee and/or	**UnitedHealthcare Provider Portal (Front Door):** Secure provider portal provides a central access point where enrolled providers have access to eligibility and benefits, claims management, claims reconsiderations, enhanced online authorizations, and gaps in care, and where they can update their practice profile. Additionally, providers can view and provide feedback on the initial health risk screening and care plans in ICUE.	Over nine years	N/A	Adobe Experience Manager	Linux App deployed on AEM	Linux App is Deployed on AEM

provider inquiries, suggestions and complaints						
	myuhc.com: Secure health and wellness information is available 24 hours a day, seven days a week through our enrollee portal. Enrollees register for online access by setting up a secure HealthSafe ID™ and password. The personalized and easy-to-navigate digital experience enables enrollees to search for covered benefits, manage personal preferences, update contact information (including email addresses), view/print and request a mailed ID card, change their PCP and locate providers through a searchable Provider Directory. The portal offers personalized health and wellness content such as seasonal reminders (i.e., flu shots), personalized care recommendations, links to plan programs, and links to online resources and tools. Content is available in multiple languages and compliant with Web Content Accessibility Guidelines.	Over nine years	MS SQL Server DB2	DB2 - IBM MYSQL - Redhat	AIX Linux	IBM RedHat

2.6.13.2.3 All proposed functions and data interfaces;
2.6.13.2.4 Data and process flows for all key business …

Our suite of systems is deployed across our Medicaid contracts and supports all critical program functions including enrollee and provider management, plan and reference data management, care coordination and utilization management (UM), claims and encounter processing, third party liability (TPL), financial management, program integrity management, quality improvement, analytics and reporting, and data exchanges internal and external to our organization.

As shown in figures 5 and 6 at the end of this section, UnitedHealthcare's management information systems (MIS) interfaces and architecture that support all critical functions for LDH's model. They illustrate how UnitedHealthcare systems interface and exchange data with LDH and the key business processes — Enrollee, Provider, Encounters and Clinical—associated with those interfaces.

Note: All data exchanges we send and/or receive from the LDH go through our secure connection platform, Electronic Communication Gateway (ECG).

Our Claims Management Solution Optimizes Exchange of Information

Our Community Strategic Platform (CSP) is the core of our MIS architecture. CSP takes advantage of the platform's throughput and ample capacity (over 600 terabytes of data storage), and is co-resident on the Exadata platform with our Strategic Management Analytic Reporting Tool (SMART) data warehouse and our National Encounter Management Information System (NEMIS) encounters reporting system, reducing data latency for reporting to virtually zero.

Additional flowcharts and descriptions of UnitedHealthcare's systems are provided at the end of this section and apply to each region in Louisiana.

Enrollee Eligibility, Enrollment and Disenrollment Management

Our enrollee eligibility, enrollment, and disenrollment management flowchart outlined in figure 5 illustrates how the enrollment files we receive from the LDH go through ECG, our secure connection platform. From ECG, the enrollment file is pushed to EEMS for processing and loading to CSP and our activity monitoring platform, Alvar. Within CSP, the file populates and refreshes databases that key functional areas use to manage business operations such as:

- Processing claims
- Checking enrollee eligibility and responding to queries about enrollment status
- Making PCP auto-assignments
- Quality-checking data and route errors for correction to the enrollee services team
- Generating operational and state-specific reports
- Adjusting workflow management activities

Data Shared Simultaneously and Securely Across Systems

Data in the files is shared simultaneously with other systems, such as the 270/271 transactions with claims clearinghouses, our call center interactive voice response (IVR) system, enrollee and provider portals, and our SMART data warehouse for reporting and analytics purposes. Enrollment and eligibility updates are shared with subcontractors (e.g., dental, transportation, vision) and

downstream operations such as ID card fulfillment, coordination of benefits (COB) and care coordination activities.

Claims Processing Edits, Corrections and Adjustments

Our claims processing and encounters process is provided in figure 8 at the end of this section. Claims are checked for compliance and validated through automated processes when they arrive. They are then routed to the appropriate claims system based upon enrollee identifiers. Validated claims are then checked against various claims system edits and rules. Figure 8 shows how we first receive a claim, either as a paper claim received directly from a provider or through clearinghouses. The claims processing sequence then continues:

- Our claims rules engine applies COB and TPL details.
- Claims are loaded into our CSP pre-processor, where the enrollee and provider on the claim are identified.
- Claims with errors are routed for manual review, updated or corrected (if applicable), then rejected or routed for processing in the next cycle.
- Adjudication-ready claims go through processing, where claim editing rules are applied (for example, authorization verification, pricing, provider network status, benefits or copay).

Upon completion of the claims adjudication process, payment is made to the provider by either check or electronic funds transfer (EFT). Processed claims are then routed to NEMIS, our encounter data system, for encounter data validation, submission and reporting purposes. We receive claims via EDI, portal, and paper, and then load the data into CSP.

Systemic Edits Identify Claims Issues

During the claims processing review, claims are subject to several systematic edits to identify unanticipated claim billing patterns or potential questionable billing practices.

Once claims processing completes, our Smart Audit Master (SAM) system randomly samples processed claims. Claim auditors then access the selected claims within SAM and review them to determine processing accuracy. We use CSP's editing tool to rigorously review all claims before payment. With a knowledge base that contains up-to-date code sets — updated regularly as rules and codes change, and current industry standard guidelines for many codes and claim situations — the editing tool can apply local exceptions. Further, it screens for: unbundled codes; up-coded, invalid and duplicate codes; code fragmentation; enrollee age; enrollee gender; place of service; pre- and post-operative intervals; and modifiers. Through our editing process, we manage provider reimbursement policies for both professional and institutional claims.

Claims Payment and Prompt Payment Guidelines

Throughout our described claims process and under program integrity, we monitor operations to maintain timely action on both clean and unclean claims.

Maintaining and updating our CSP configuration is a key component of claims payment accuracy. CSP is configured to align with our Claims Quality Assurance program and built upon a set of quantifiable measures to continually verify we are processing and paying claims on time and accurately. Our Claims Quality Assurance program consists of pre- and post-disbursement review and prevention, including root cause analyses and rapid deployment of solutions to avoid provider

abrasion. All audit review outcomes are documented and kept on file for trending and reporting purposes.

Coordination of Benefits for Claims with Third-party Liability

Our third-party liability (TPL) subsystems work in conjunction with our claims and utilization review subsystems to continually mine for TPL and to apply coordination of benefits (COB) edits, making sure Medicaid is the payer of last resort, as figure 9 at the end of this section shows. Our COB and TPL subsystems contain integrated managed care information system constructs built on the TriZetto Facets platform, which meets all applicable state and federal laws and privacy regulations including HIPAA. Figure 9 depicts how claims flow through CSP to be subsequently adjusted based upon TPL, COB, subrogation and other cost-avoidance activities.

Encounter Submission Including Statistics for Percentage Accepted and Denied

NEMIS, our encounter data submission and reporting system, initiates submissions, tracks responses, and provides error correction and resubmission of encounter data. Developed by UnitedHealthcare, NEMIS facilitates reliable reporting built on sound, accurate data to bring workstreams together to enable effective management of encounter data in specified formats.

As our statistics from over the last four years show, UnitedHealthcare has a long track record of high performance in submitting timely, accurate and complete encounter data to LDH:

- **Acceptance.** Over the past four years, the monthly acceptance rate has been in the 99% range for all Healthy Louisiana encounters submitted.
- **Timeliness.** Over the past four years, an average of 95% of medical and pharmacy encounter data have been submitted within 35 days of claims payment.

How Encounter Data Statistics Are Measured and Tracked

To measure overall encounter completeness, we load all adjudicated claims into the NEMIS encounter system to verify the full population of claims is available for submission and use when measuring the claim or paid dollar submission completeness and timeliness of encounter submissions. Within NEMIS, encounters are flagged and matched to the 835 response files to reconcile their status, measure acceptance rates, and identify reject reasons for each submission. Both threshold and warning edits returned in the 835 response are stored within NEMIS, enabling our encounter data management team to monitor both types of errors and take appropriate action.

Figure 10 at the end of this section depicts the encounter submission process. Our encounters systems work together with our claims, TPL and SURS subsystems. NEMIS generates integrity reports that search for questionable data received from our subcontracted vendors, allowing us to review discrepancies and take appropriate corrective action. Using NEMIS, we analyze medical claim, encounter, enrollee and provider data, and identify deficiencies in the quality and completeness of all data.

Provider Enrollment and Network Management

Our provider enrollment and network management flowchart (figure 11) show how provider demographic and contract data is loaded into our national database (NDB).

Provider information is collected and collated from all available sources and loaded or keyed into NDB. Demographic information and network associations flow to CSP Facets, which flows enriched data downstream to key systems, including directories. Applications not needing the CSP-enriched data to associate claims or identifiers can alternately connect to the Provider Elastic Search Tenant.

Care Coordination System and Portal and Interface with Claims and Provider and Enrollee Portals

Our clinical and care coordination platform interfaces with an array of our other internal systems to make information available where needed for our case managers, enrollees and providers. As shown in figure 12, our clinical platforms not only connect with our provider, eligibility and claims platform to manage utilization and prior authorizations and draw in data from HIEs and EHRs and results from our clinical quality (HEDIS) and risk identification and stratification analytics. In addition, various assessment and plan of care information is available in our data-mart and from our portals.

Financial Management and Accounting

Figure 13 at the end of this section diagrams how our financial subsystems interconnect with our claims platform, payment and invoicing, pricing, reporting and other systems in support of financial management and business accounting.

Program Integrity

In support of program integrity management, our comprehensive Surveillance Utilization Review Subsystem (SURS) captures enrollee- and provider-specific information (including subcontractor information) and complies with the requirements of 42 C.F.R. 455. Figure 14 at the end of this section shows how our SURS supports a multitude of quality improvement, utilization management, profiling, reporting, investigating and monitoring activities aimed at reducing fraud, waste and abuse (FWA) and continuous quality improvement.

Reporting Systems

Figure 15 at the end of this section depicts our systems that enable us to achieve maximum plan effectiveness and to meet LDH's reporting requirements. Our business intelligence (BASIS) reporting team and end-users access SMART and use its data analytics toolset to analyze data and produce internal and external reports.

Information Technology
General Requirements System Interfaces

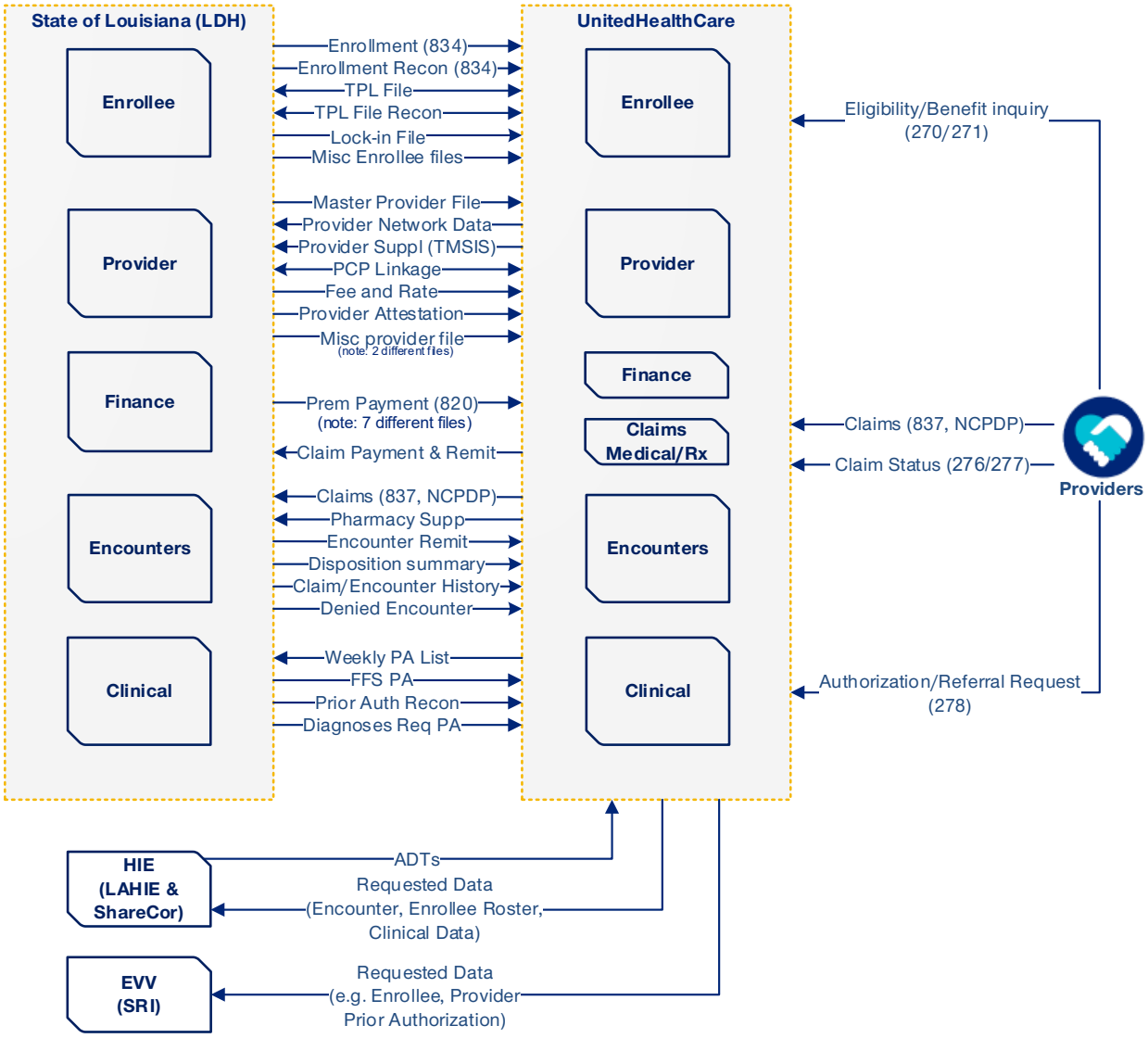


Figure 4. UnitedHealthcare systems interface and exchange data with LDH and the key business processes.

UnitedHealthcare – Louisiana Architecture

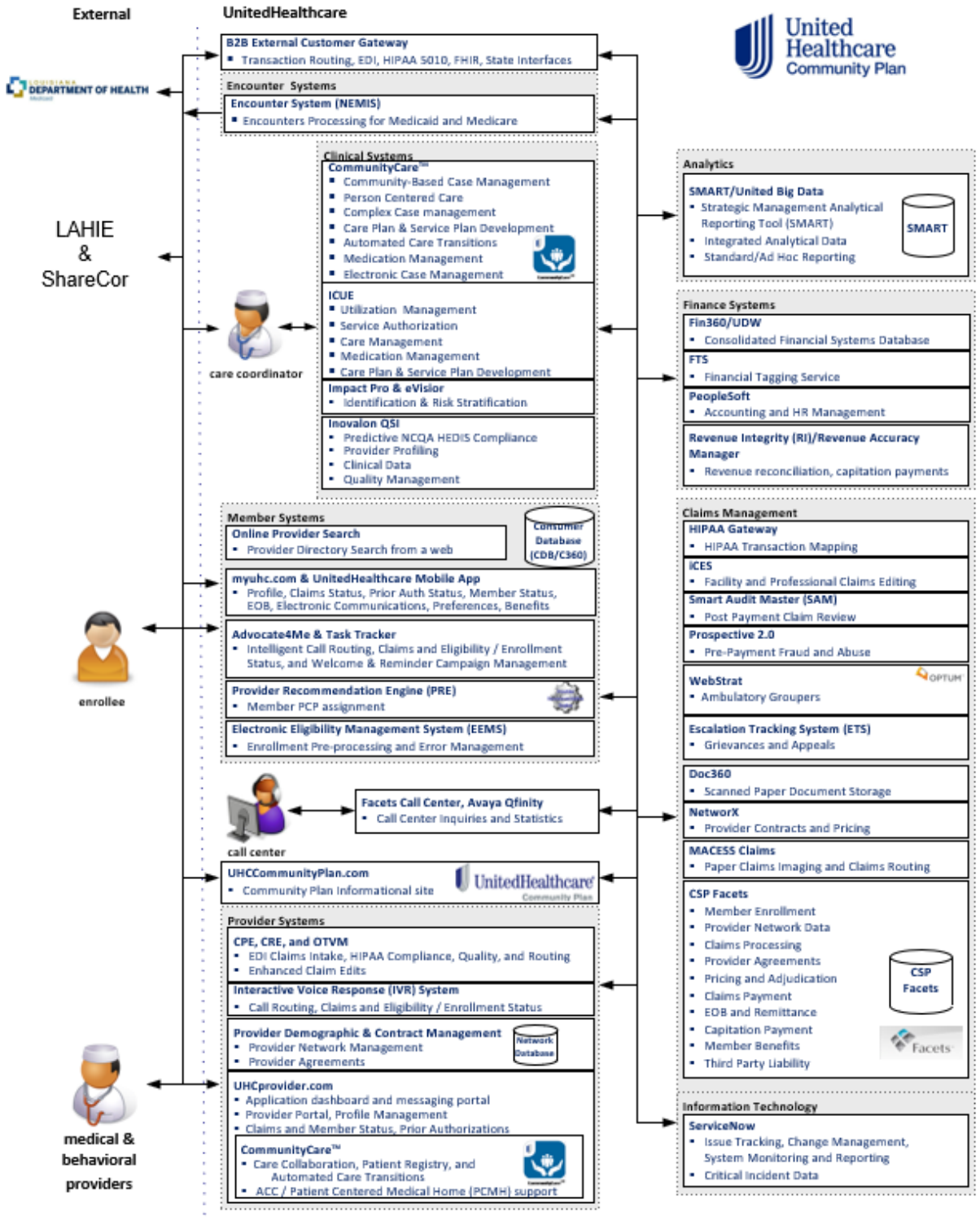


Figure 5. UnitedHealthcare's management information systems (MIS) architecture fully supports all LDH critical program functions.

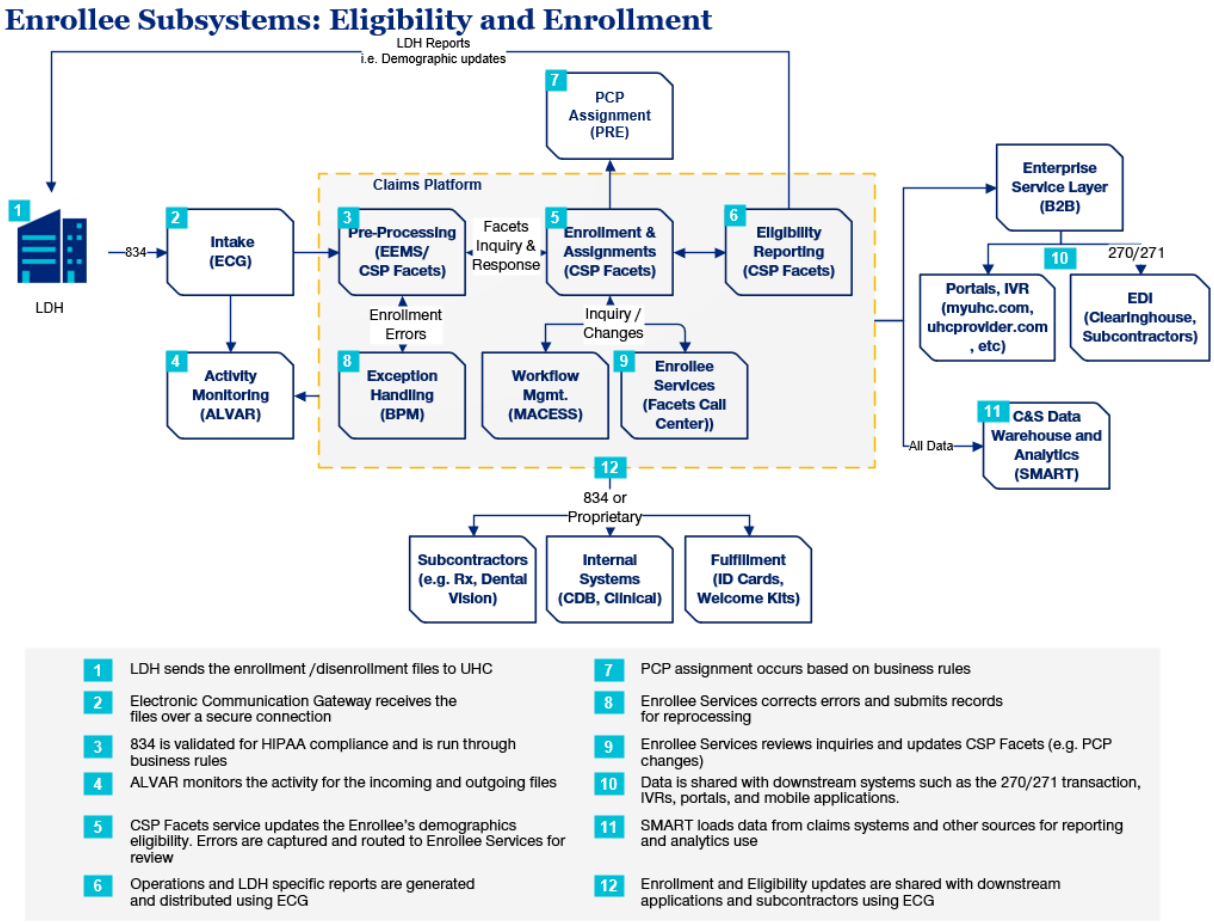


Figure 6. Enrollment/Eligibility Subsystem Flow. Our end-to-end enrollment flow validates inbound 834 files for HIPAA compliance and loads the data into our CSP system.

Claims Subsystem

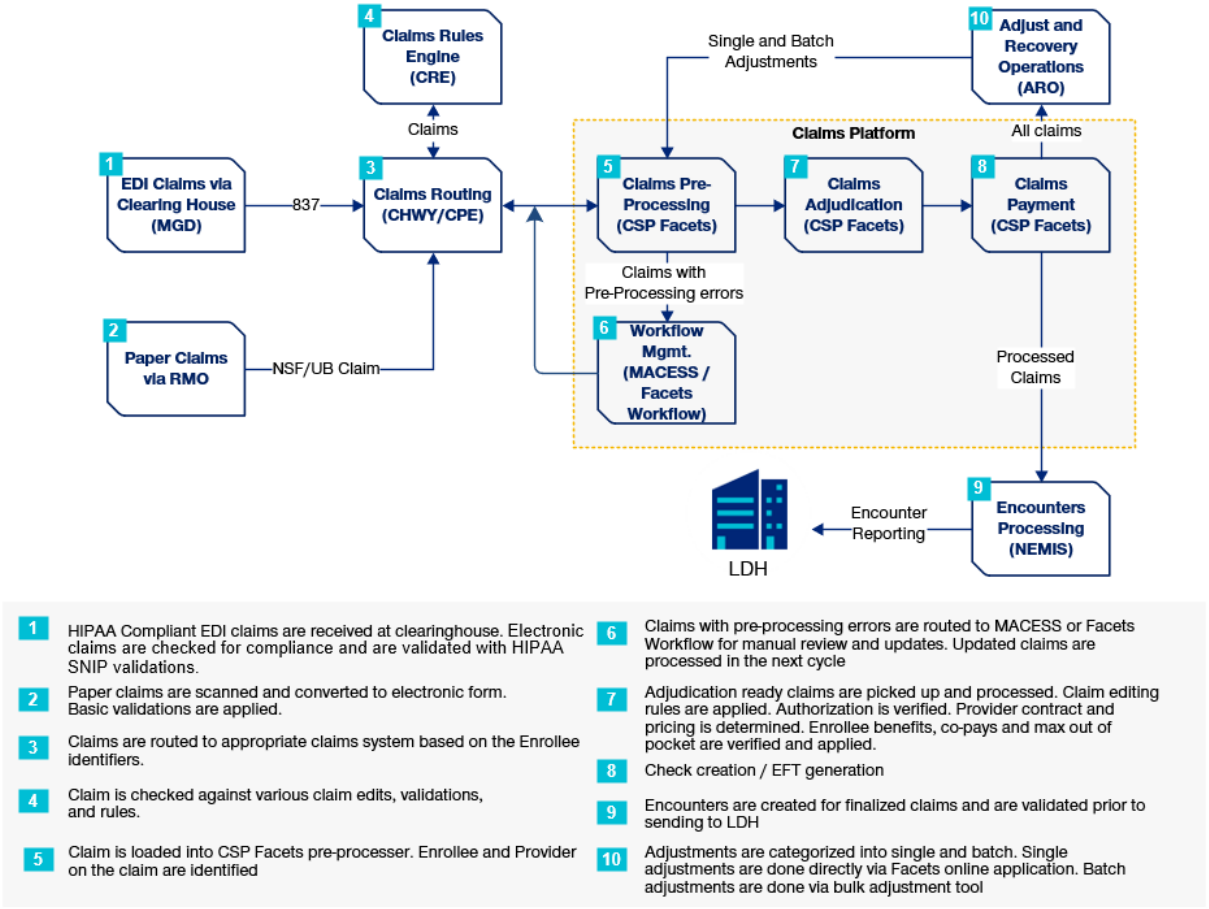


Figure 7. Claims Processing and Encounters. We receive via EDI, portal, and paper, and load the data into CSP.

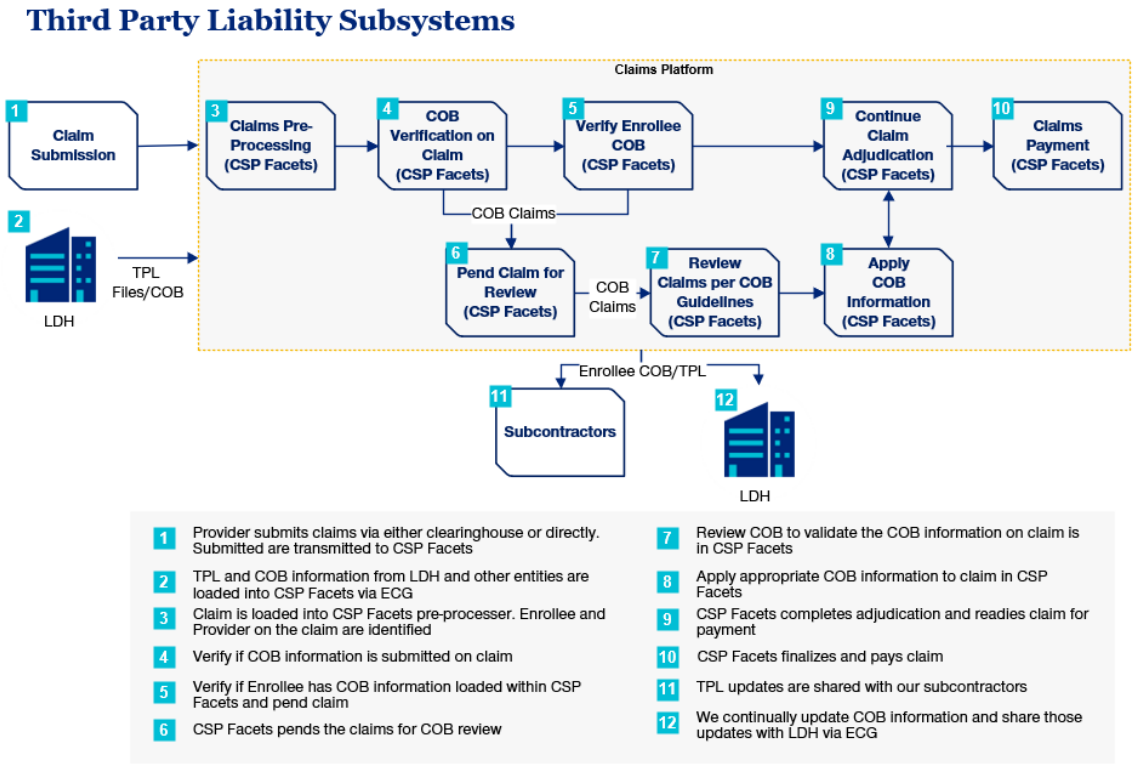


Figure 8. Claims flow through CSP to be adjusted based upon TPL, COB, subrogation and other cost-avoidance activities.

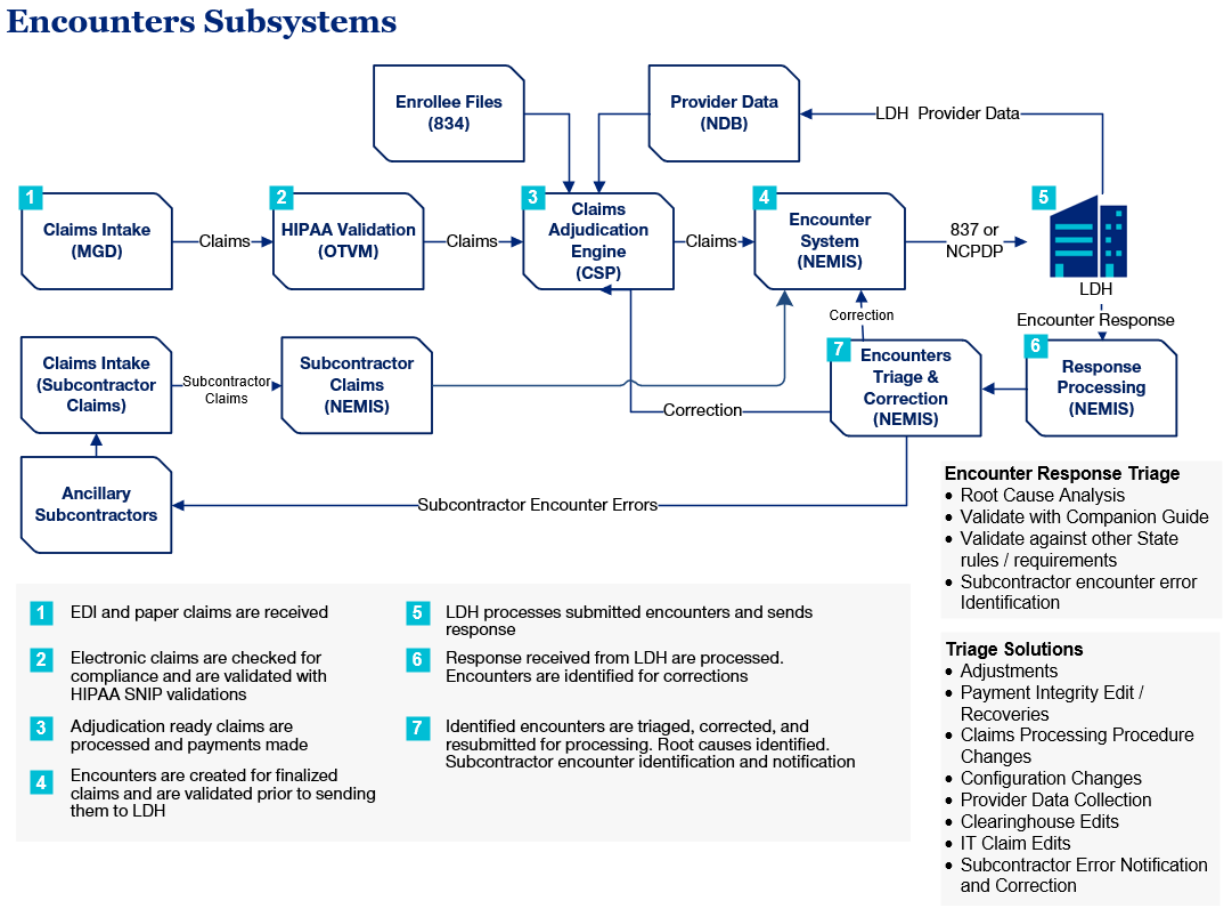
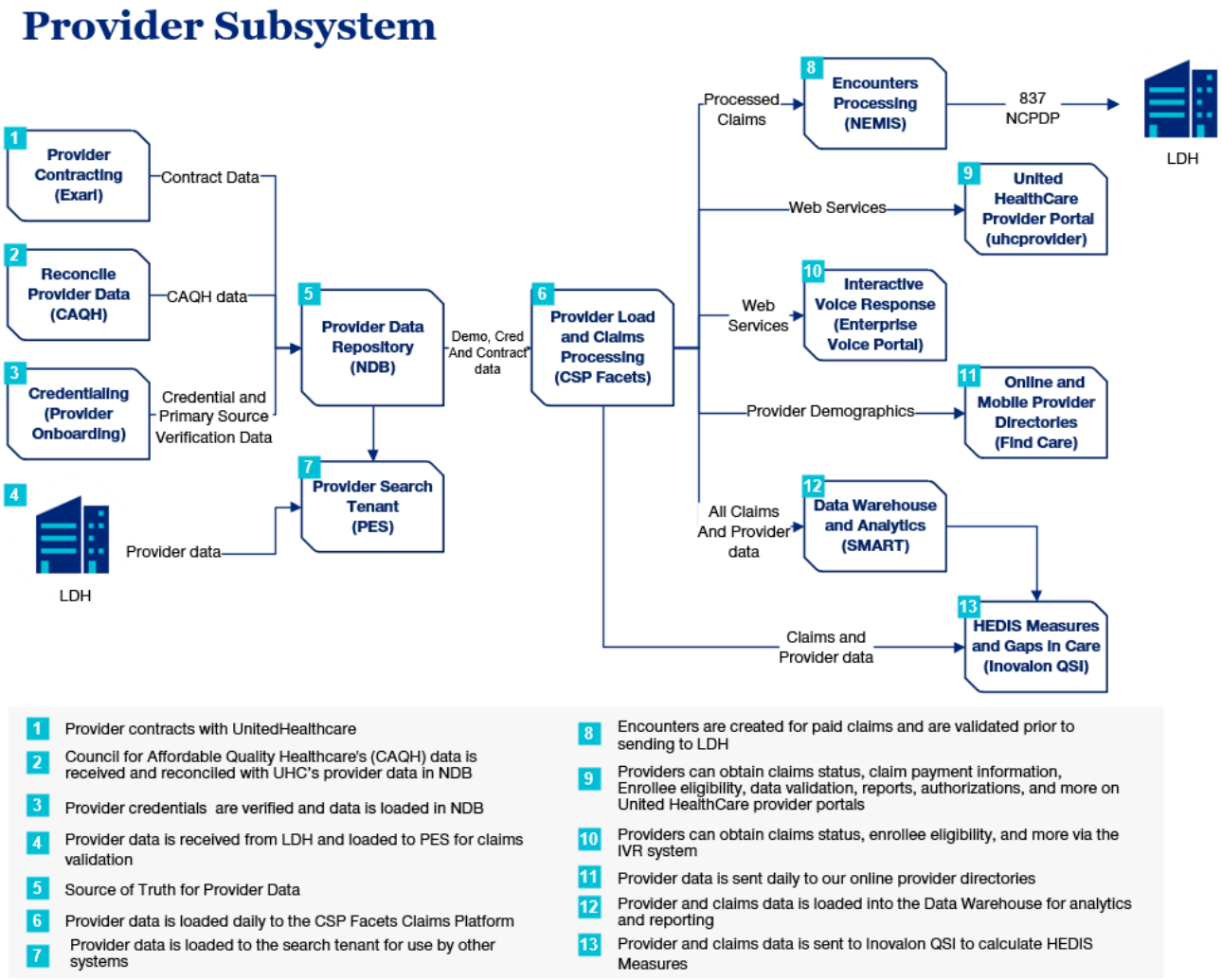


Figure 9. The UnitedHealthcare encounters systems work together with our claims, TPL and SURS subsystems.



1. Provider contracts with UnitedHealthcare
2. Council for Affordable Quality Healthcare's (CAQH) data is received and reconciled with UHC's provider data in NDB
3. Provider credentials are verified and data is loaded in NDB
4. Provider data is received from LDH and loaded to PES for claims validation
5. Source of Truth for Provider Data
6. Provider data is loaded daily to the CSP Facets Claims Platform
7. Provider data is loaded to the search tenant for use by other systems
8. Encounters are created for paid claims and are validated prior to sending to LDH
9. Providers can obtain claims status, claim payment information, Enrollee eligibility, data validation, reports, authorizations, and more on United HealthCare provider portals
10. Providers can obtain claims status, enrollee eligibility, and more via the IVR system
11. Provider data is sent daily to our online provider directories
12. Provider and claims data is loaded into the Data Warehouse for analytics and reporting
13. Provider and claims data is sent to Inovalon QSI to calculate HEDIS Measures

Figure 10. Our simplified credentialing process supports data sharing and administrative simplification for providers.

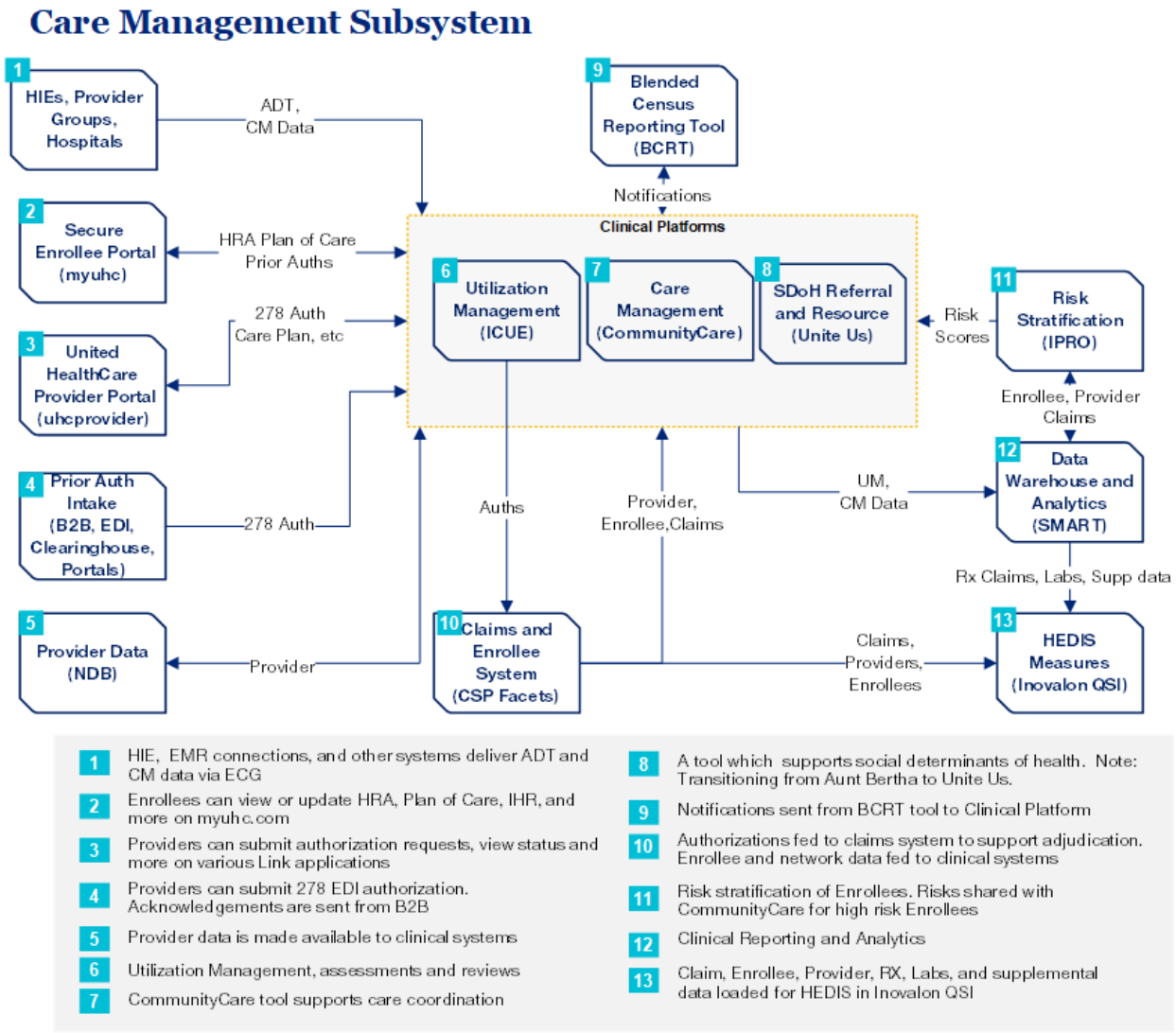


Figure 11. We consume clinical data (e.g., ADTs, 278) and make available to the teams/people responsible for the enrollees' care.

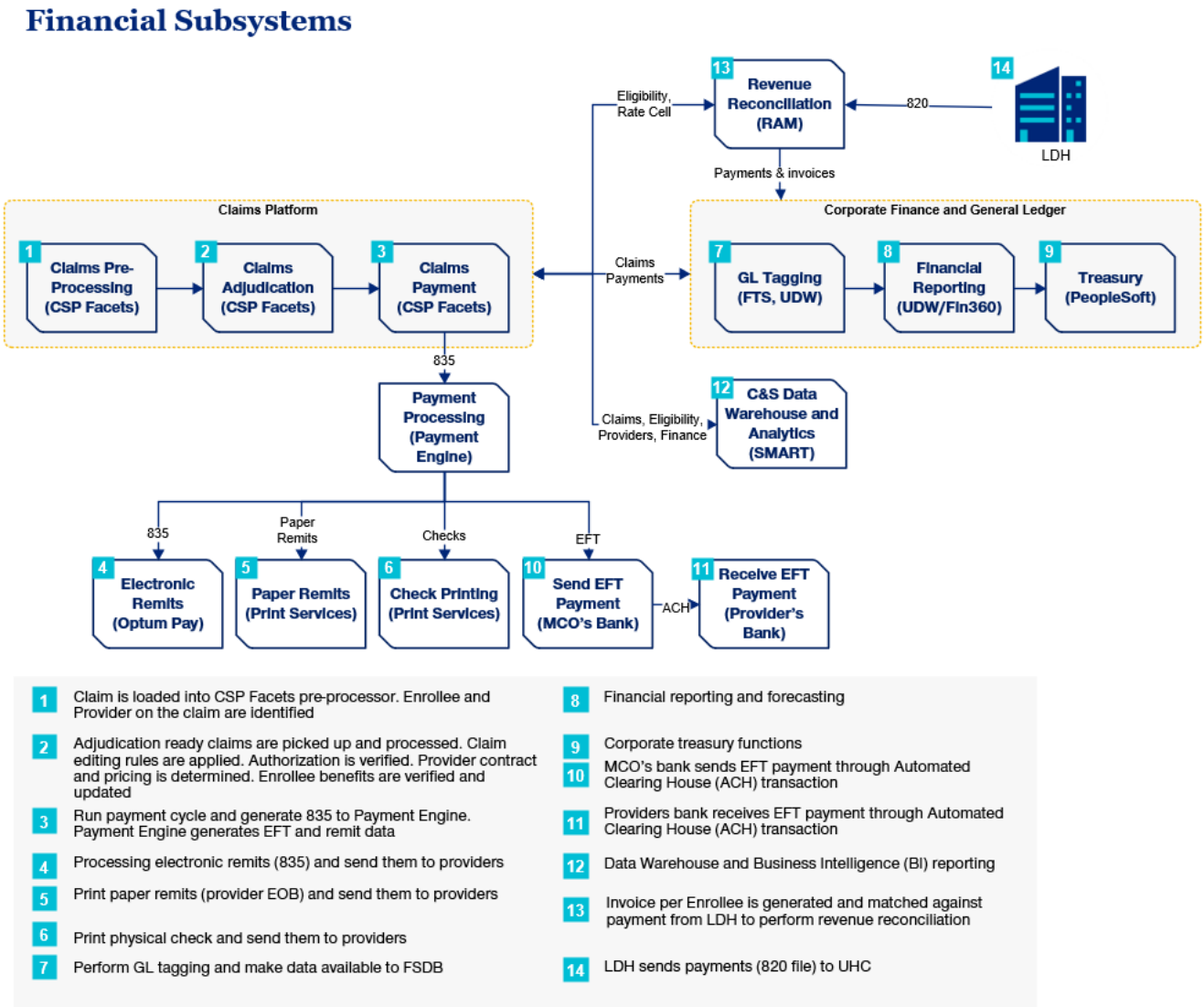


Figure 12. Our claims payment process enables prompt and timely payment to providers.

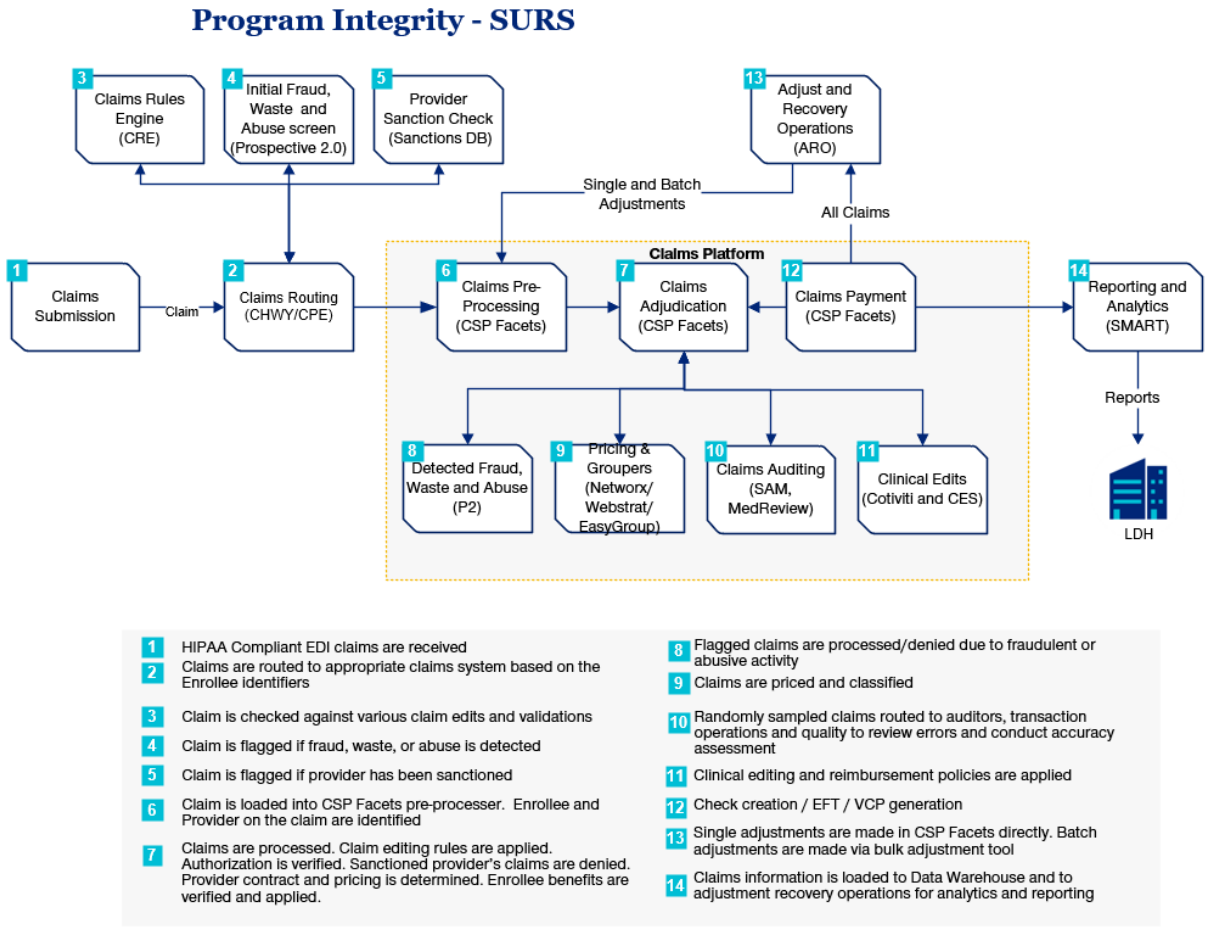


Figure 13. SURS supports improvement, utilization management, profiling, reporting, investigating and monitoring activities for both FWA and continuous quality improvement.

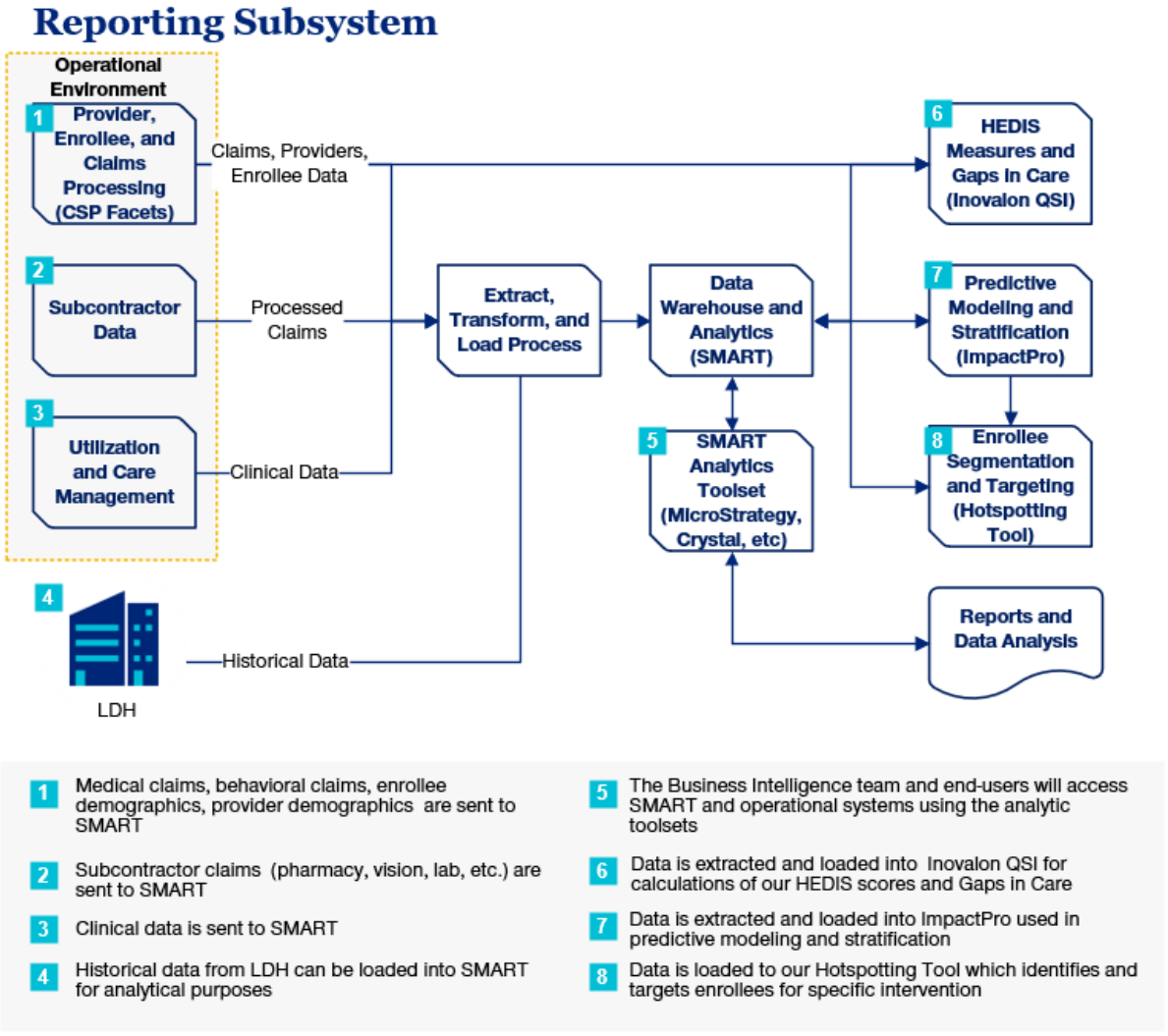


Figure 14. Our integrated reporting and data analytics solution enables us to achieve maximum plan effectiveness and meet LDH's reporting requirements.

2.6.13.2.5 Proposed resources dedicated to Medicaid Management Information System (MMIS) exchanges.

The IT technical support for Louisiana requires 57 FTEs per year. This includes eight FTEs to monitor infrastructure and technical operations and 49 FTEs to provide platform technical support. In addition to those, 11 local system support staff are dedicated to supporting the Louisiana program. Our dedicated information management and systems director has accountability for the technology supporting the Louisiana Medicaid Managed Care program. The local support staff dedicated to Louisiana includes an information management and systems director/chief information officer (Glennis Johnson); IT systems analyst, operations support; IT systems analyst and HEDIS reporting manager.

In total, we anticipate the Louisiana Medicaid program to require 68 IT resources to continue to support the program. This represents a fraction of our overall IT support staff who can be accessed as needed to assist Louisiana Medicaid. UnitedHealth Group IT has more than 9,700 technology professionals across the United States. Following industry standards, our IT professionals are geographically dispersed to take advantage of the national labor pool and mitigate localized disaster and weather events risks. The technology resources have mandated annual training that is not role-specific. As an organization, we target 5% of each technology resource's time to continuing education.

2.6.13.3 The Proposer should describe in detail any system changes or enhancements that the Proposer is … **2.6.13.3.1** Enrollment; 2.6.13.3.2 Claims processing; **2.6.13.3.3** Utilization management/service authorization; or **2.6.13.3.4** Care management/disease management.

Innovations and Platform Enhancements

We are dedicated to continuous improvement, and we invest in information systems — people, process and technology — to keep us on the leading edge of technology and technological capabilities. There are no plans to subcontract any part of our system(s) to a material subcontractor. While we continuously invest across our IT portfolio, our significant current and ongoing innovations and enhancements include:

- **Upgrades to Facets:** To maintain support and compliance, we upgrade CSP to the most recent, leading-edge version of Facets twice per year. We continue to raise the bar and are in the early stages of planning to run three upgrades per year to make certain we are taking advantage of its full capabilities release to release.
- **Technology Modernization:** Ongoing investment in multiple functional areas to improve automation, advance real-time transaction processing, advance quality, reduce infrastructure cost via cloud deployment, and benefit from other modern technologies.
  - Claims Highway modernization (Modernized B2B, UFE) — including ACE (Advanced Communication Engine) Edits
  - Claims Editing System (CES): We are investing to consolidate and upgrade the Medicaid and Commercial instances of our Claim Editing System (CES) for both professional and facility claim edits
  - CMS Interoperability APIs deploying on rolling schedule per CMS
  - "Big Data" enhancements for improved analytics and AI/ML
  - Spire and Maestro — Modernized provider and enrollee Call Center platforms with integrated system's data (Claims, Grievance/Appeals, Clinical), with phased feature deployments

- **Provider Portal Enhancements:** We continue to improve our provider portal experience by simplifying how providers do business with us. Investing in improvements to the provider portal, we improve ease of use and expand capabilities ongoing. Standard administrative functions are available directly from *UHCprovider.com*, alongside the related content from the *Care Provider Manual* and bulletins. Application workflows are simple and straightforward, with enhancements for usability and accessibility. Enhancements also will be made to value-based contracting, capitation and delegation features.
- **Health Information Exchange (enrollee, provider, care management):** UnitedHealthcare is dedicated to enabling the electronic sharing of clinical data to facilitate the quality of care for our enrollees. We have extensive experience engaging with industry leaders related to clinical data management and exchange**.** Nationwide, we connect to hospital direct submitters, health systems, HIEs and ADT aggregators. At last count, we received ADT transactions from 24 HIEs and 58 direct submitting health systems covering hundreds of hospitals, plus we connect with the national labs for results. We engage with the five major EMR vendors/platforms and over 1,200 hospital EMRs to exchange clinical data. We contract with all vendors that release significant information to acquire clinical records. We are working on ingesting clinical records (e.g., ADT, CCD) from external sources with better speed and quality. This will allow the care managers and care teams to react more expeditiously, directly affecting the enrollee. While all this happening nationally, these capabilities are being actively worked on with HIE vendors representing the Healthy Louisiana population.
- **Interoperability (enrollee, provider, care management):** We have developed a long-term strategy to support bidirectional, standards-based, information exchange, and we are currently building this capability to enable bidirectional collaboration and real-time coordination of enrollee individual plans of care through the Da Vinci project. As a cofounder of this initiative, and ahead of the CMS Interoperability rule, UnitedHealthcare helped payers and providers positively affect clinical, quality and cost of care outcomes. This project focuses on adoption of HL7 Fast Healthcare Interoperability Resources (HL7 FHIR) as a foundation for driving critical value-based care use cases. Ahead of Da Vinci publishing standards and the CMS Interoperability rule, we brought to market our EMR Point of Care Assist® technology to improve collaboration and enrollee care.
- **PULSE:** Pulse monitoring uses transaction baselines and alert thresholds to proactively identify and address system bottlenecks. This tool has enabled us to avoid many priority war rooms to address application issues while improving application availability and claims processing speed. Started with CSP Facets, we are expanding this monitoring across key assets in our portfolio.
- **Hotspotting (enrollee, care management):** Our Hotspotting tool allows us to quickly identify enrollees with high needs or high costs (e.g., medical, behavioral, health-related resource needs) to better address their complex needs and SDOH in our ongoing efforts to reduce the total cost of care.
- **Chatbots (enrollee, provider):** Our SOPHIA artificial intelligence (AI) chatbot is built with embedded standard operating procedures (SOPs) and platform APIs to automate and support functions our customer service and claims operations personnel perform. The chatbot automatically looks up SOPs and populates data and directions to screens for staff when required. This automation improves the efficiency of our staff in assisting our enrollees and providers with the accuracy of data entries during calls and claims processing. We continue to

explore opportunities to add chatbots and capabilities to support our staff to improve accuracy and efficiency.

- **IHR Application (enrollee, provider):** Our Integrated Health Record (IHR) application is deployed for provider and enrollee use, and we continue to enrich its data. The IHR provides an integrated dashboard of individual enrollees' health records, with a detailed view of claims, prescriptions, problems, opportunities and gaps in care, prior authorizations and more.
- **Enrollee:** In addition to the interoperability, we are working on improving the capability in our enrollee portal (*myUHC.com*) for enrollees to search and display benefits, among our ongoing programs to continue to improve the user experience. Also, we are working on better capturing and representing race, ethnicity, language preference and gender for use by our downstream applications.
- **Clinical Services:** Phased integration with Optum Care Manager and transition from ICUE. Targeted for 2022 and later, this integration will modernize and upgrade the ICUE platform module by module.
- **Provider:** Continued modernization of legacy provider demographics and contracting platforms, including improvements to our directory generation process.

2.6.13.4 The Proposer should describe the capability and capacity of the Proposer's Information Technology …

We currently serve LDH and have all the required interfaces in place and operational (as provided in Sections 2.6.13.2.3 and 2.6.13.2.4.). We understand health care is a very complex business, and the integration of a health care delivery system is no small undertaking. We recognize the challenges of developing and integrating health care delivery systems, including working with external partners and providers with various levels of expertise and diverse technologies and interfaces. We have significant experience working with regional and statewide partners in numerous states in facilitating effective implementation, self-sustainability and adoption of new technologies. Today our shared platform supports 31 states, 7,000 concurrent users, more than 7 million enrollees, and adjudicates more than 500,000 claims per day.

We recognize the importance of implementing and maintaining sufficient information technology systems capability and capacity, and proactively identifying needed expansion or upgrades to support our enrollees, providers and state partners with expedient and continuous information technology operations. These are key elements of our proactive approach to assess and address needs:

- **We assess system capability and capacity needs** using predictive modeling to forecast anticipated changes, in combination with continuous performance monitoring of key system indicators. We use this information to proactively create plans to increase capacity before it is needed.
- **Our flexible and scalable systems architecture enables us** to quickly expand capacity without risk or material operational impact.
- **We continuously invest in our technology capabilities** and have access to significant national information technology resources.

Approaches and Experience with Data Exchanges

To optimize implementation and maintenance costs, we align our interfaces to industry standards wherever possible, producing a canonical format we then tailor for our state partners. We can

restrict or filter fields by external partner, and we have control over the membership each partner sees, allowing us to control the specific product, line of business, or waiver populations sent to each system and external partner. Where appropriate, we redact sensitive diagnoses, Social Security numbers and other fields in interfaces.

- External partners can take advantage of either the standard batch interfaces or a variety of secure and authenticated services, with content and access limited by business need. Ahead of the CMS Interoperability rule, we have built capabilities to enable bidirectional collaboration and real-time coordination of enrollee care plans through the Da Vinci project. As a co-founder of this initiative, UnitedHealthcare helps payers and providers positively affect clinical, quality and cost of care outcomes. This project focuses on adoption of HL7 Fast Healthcare Interoperability Resources (HL7 FHIR) as a foundation for driving critical value-based care use cases. Ahead of Da Vinci publishing standards and the adoption of the CMS Interoperability rule, we have gone to market with our EMR Point of Care Assist technology to improve collaboration and patient care now.

We rely on our secure Electronic Customer Gateway (ECG) as the common enterprise facility to exchange files between both internal entities and between UnitedHealthcare and external partners and customers. The ECG provides:

- Secured transport, logging and nonrepudiation of file transfers between the State, UnitedHealthcare and external parties
- Secured file exchange between internal servers
- Performance reports and audit reporting
- IT security compliant connectivity

Data and File Exchanges
Using our secure Electronic Customer Gateway (ECG), we exchange over 27 million files in any given month, and we project that we will securely exchange **over 310 million files** with our customers and partners in 2021.

ECG supports multiple secure transport methods, including the most often used secure File Transfer Protocol (sFTP). All UnitedHealthcare file transfers go through our ECG, either via standing sFTP drop-box or through use of our on-demand, quick-connect facility. We use logging and automation to monitor and coordinate with external partners to confirm valid and complete data exchanges, while maintaining full audit trails.

2.6.14 Program Integrity [10-page limit]

2.6.14.1 The Proposer should describe its fraud, waste and abuse program and how it addresses the requirements …

UnitedHealthcare Fraud, Waste and Abuse Program

UnitedHealthcare not only meets and exceeds the standards in the model contract, we continue to be a leader among MCOs in Program Integrity for Louisiana, through savings and recoveries, tips and referrals and innovative prevention programs. Our commitment to the highest standards of integrity and vigilant stewardship of Louisiana's Medicaid funds since 2012 provides enrollees appropriate access to the care they need to live healthier lives. Our anti-fraud, waste and abuse (FWA) activities have resulted in significant savings and recoveries. **Since 2015, as a full risk plan, we have achieved over $16 million in savings and recoveries for the State of Louisiana, growing annually from $900,000 in 2015 to over $4 million in 2020.** Our extensive experience and resources have resulted in over 1,100 tips and over 600 referrals to the State since 2015. We have averaged over **190 referrals in the last two years**. We continue to launch innovative programs and strategies for prevention purposes. Our leadership is further demonstrated through our collaboration with the Louisiana Department of Health (LDH) and other MCOs, helping LDH achieve its aim for fraud prevention through innovation, increased productivity, communication and results.

Above and Beyond on Annual Referrals

In August 2018, LDH acknowledged that we exceeded the annual goal of 50 referrals by submitting 128 referrals. In February 2019, CMS stated "Louisiana was recognized this week by the federal Centers for Medicare and Medicaid Services (CMS) for implementing best practices aimed at eliminating waste, fraud and abuse... Louisiana is one of only eight states to receive this honor."

Our FWA program includes an experienced and comprehensive Special Investigation Unit (SIU). With at least one Louisiana-dedicated investigator per 50,000 enrollees, our staff have diverse backgrounds, including Certified Professional Coders (CPC), an Accredited Health Care Fraud Investigator (AHFI), certified investigators, a Registered Nurse (RN), and a manager with a law degree (JD). Currently, consisting of 10 positions coordinating and conducting investigations, our Louisiana investigations team continues to grow in step with our membership, with the team having the flexibility to draw upon local resources to keep pace with the current environment, and have access to national resources to support its activities.

UnitedHealthcare recognizes **the best time to address FWA is before a claim is paid**. With our LDH partners, we continue to be a leader for new opportunities in program integrity, safeguarding the programs with state-of-the-art, up-front prevention strategies that avoid inappropriate spending and save the State of Louisiana substantially more dollars. For example, in addition to algorithmic tools, we have two programs that reduce the possibilities for claims payments to phantom entities. Our **Enhanced Provider Verification (EPV)** breaks the "pay and chase" model by targeting new, out-of-network (OON) providers on first taxpayer identification number (TIN)/claim submission. Our **Independent Pharmacy Enhanced Credentialing (IPEC)** program, which we have recently deployed in Louisiana, applies an enhanced credentialing algorithm for independent retail pharmacies located in high-risk parishes to confirm these pharmacies exist and are not FWA fronts.

Our parent company, UnitedHealth Group, and our employees, subcontractors and enrollees all support a compliance culture focused on the seven elements of an effective compliance program and are fully compliant with all requirements of the Model Contract, Part 2.20, Fraud, Waste, and Abuse Prevention.

Figure 15. UnitedHealthcare uses the seven elements of an effective compliance program to establish a culture of effective compliance.

The UnitedHealth Group Code of Conduct is the foundation of the compliance program. Supported by policies and procedures, oversight, training and education, effective lines of communication and reporting, monitoring and auditing, responses to detected offenses, and enforcement standards, this structure is the foundation of our FWA prevention efforts. All are detailed in our FWA Compliance Plan, which we submit for written approval to LDH annually, and upon update or modification, at least 30 calendar days before making effective.

Advance Health Equity

Contract compliance officer and program integrity officer Stephen Long works with our national and local SIU and payment integrity departments, which are all supported by our legal team. Alongside our health plan CEO, Mr. Long co-chairs our local Compliance Oversight Committee to oversee the compliance program and confirm adherence with LDH requirements, policies and procedures. Mr. Long participates in our Member Advisory Committee to make sure our enrollees' voices remain front and center in our compliance work. Further, he will collaborate with our Louisiana Health Equity (HE) Administrator if any indications of structural racism or bias are identified.

With the health plan's CEO and/or COO and the Louisiana SIU team, he attends LDH Program Integrity (PI) and Louisiana Office of Inspector General's (OIG) Medicaid Fraud Control Unit (MFCU) meetings, where investigative units share schemes and case studies that inform and impact our investigations**. In addition to providing information to attendees at these meetings, our investigators often initiate follow-up meetings with other MCOs to collaborate on FWA schemes, findings and actions related to similar investigations.**

Prevention, Detection and Correction

A cornerstone of our compliance program, our Anti-FWA program focuses on prevention, detection and correction activities to minimize and prevent overpayments due to FWA. Processes for preventive activities associated with cost-avoidance and detection or correction activities resulting in overpayment recoveries and continued savings are supported by the following policies and documents:

- UnitedHealthcare Compliance Program Document, FWA policy, and Investigation's policy
- UnitedHealth Group False Claims Act Compliance policy and Non-retaliation policy

- Louisiana Annual FWA Plan and supplemental documentation to address federal and state-specific requirements

Our prevention, detection and correction operational model further increase the effectiveness of our local compliance program. Drawing on the resources of our national team, our state teams share information with other states and access additional resources, when needed, to uncover potential schemes and avoid or remediate FWA in Louisiana. Our teams proactively share information with our industry partners, including LDH and the MFCU. Since **2019, UnitedHealthcare has submitted 183 referrals and notices of potential FWA**.

Figure 16. Ongoing feedback improves prevention, detection and correction efforts.

Prevention

All UnitedHealthcare employees undergo annual criminal background checks. We perform required database searches on employees, contract and contingent workers, and customers and business partners, contracted entities and providers per all requirements of the Model Contract, Section 2.20, to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. Our contracts with third parties mandate them to screen their employees as required by applicable state and federal law. Exclusion screenings are conducted against the following lists:

- Health and Human Services (HHS) OIG List of Excluded Individuals/Entities (LEIE)
- General Services Administration (GSA) Excluded Parties List Service
- GSA's System for Award Management (SAM)
- CMS's Medicare Exclusion Database
- State Board of Examiners
- Social Security Administration Death Master File (SSADMF)
- U.S. Office of Foreign Assets Control (OFAC)
- Louisiana Adverse Actions List and all state licensing boards

When we discover an entity is excluded, suspended or debarred, we report them to LDH within three business days. This includes a director, partner or officer of the health plan, subcontractors, and any consultants or employees with other arrangements to provide services material to the health plan and network providers.

As indicated earlier in the response, to minimize FWA and comply with LDH Medicaid program requirements, we apply prevention tools such as **claim-centric editing, provider peer-to peer profiling and predictive modeling** to the daily claim stream to identify potential FWA before the claim is paid. For example, our clinical edit system analyzes physician claims based upon business rules that automate reimbursement policy and industry standard coding practices. We use pre-payment data analytics to mine claims before payment to identify billing errors and irregularities. Mining results help us identify suspected provider and enrollee FWA for follow up, prospective audit and retrospective investigation. Additionally, when LDH informs us of a credible allegation of fraud against a provider, we immediately suspend payments according to 42 C.F.R. §455.23, alerting network management and claims processors. **Since 2020, UnitedHealthcare has placed 173 Louisiana providers on pre-pay flags, and there are 24 providers currently on payment suspension and are only removed at the direction of LDH.**

Detection

UnitedHealthcare employs an array of programs to combat FWA both prospectively and retrospectively. We focus on being good stewards of state and federal dollars and are steadfast in our commitment to preventing FWA, using programs and algorithms that identify problems that arise from both intentional and uninformed practices. Our Louisiana-based SIU staff are trained to monitor provider and enrollee behavior for any aberrant or wasteful trends, and to increase efficiency they build upon the best practices of our national investigative teams, including:

- Triaging all tips received to determine credibility before routing to the SIU or Waste and Error team. The SIU investigates allegations of fraud, while the Waste and Error team investigates non-fraud billing aberrations
- Streamlining the process by enabling the SIU to interact directly with LDH, including submitting referrals and notifications
- Performing pre-payment review by using algorithms to identify aberrant billing patterns that lead to SIU referrals
- Determining when announced or unannounced site visits or field audits are necessary
- Participating in the Healthcare Fraud Prevention Partnership and sharing awareness of industry trends

Effective lines of communication are a critical component of detection, and we make it easy for employees, enrollees and providers to report suspicions of misconduct, including billing fraud or unethical activities. In addition to the ability to confidentially report tips directly to our Louisiana compliance officer, we provide education on ways to report suspected FWA. With required employee training on non-retaliation policies and our commitment to maintaining confidentiality by creating a company culture where no one is afraid to raise concerns — an individual reporting an issue is kept confidential regardless of the reporting method used — all reported issues are addressed through the compliance structure and cannot be diverted by other management. **Since 2019, UnitedHealthcare has received and responded to 940 tips with potential Louisiana exposure.** In compliance with the Model Contract, we are implementing, and will check weekly, a dedicated email account to be posted on our website for employees, enrollees, providers and the general public to submit tips. This multi-faceted approach confirms we make it easy to report potential FWA issues through the channels below:

- UnitedHealthcare's Compliance and Ethics Help Center and FWA hotline (both available 24 hours a day, seven days a week)
- Human Capital via toll-free number or our company's intranet site
- Online tip referral form
- Provider and enrollee portals
- Contact numbers for OIG/HHS
- Louisiana FWA hotline

The COVID-19 pandemic resulted in new challenges for the industry such as revising detection efforts. Our FWA processes are based upon our extensive experience, and as the COVID-19 claim and billing history has matured and evolved, we have designed and deployed additional analytics (COVID-19, telehealth) based upon anticipated and known aberrant pandemic behavior. We have been able to identify schemes such as: procedures impossible via telehealth; duplicative and multiple billing of COVID-19 related testing and vaccine administration; inappropriate specimen collection associated with inappropriate or absent testing; billing for services not rendered; and inappropriate add-on services. We will continue to coordinate with national and state agencies and regulators to address emerging COVID-19 fraud schemes.

Correction

When FWA investigations reveal issues and actions are pursued, it is carried out through the following means:

- Notifying and educating the offending provider or enrollee, including educating a provider of possible changes in the contract and/or policy terms and procedures
- Creating and implementing new data mining queries/rules to detect if the scheme at issue is occurring with other providers
- Issuing a corrective action plan to the provider and/or referring the provider to network management for appropriate disciplinary action
- Referring the provider to any other committees as necessary to remediate the issue (such as quality, contracting or credentialing)
- Reporting the provider to state professional licensing authorities and medical boards
- Referring the matter to outside counsel for civil litigation
- Referring the matter to law enforcement officials or prosecutors for criminal prosecution

Our compliance officer and the business leaders monitor and evaluate the implementation and progress made under the corrective action plan and validate remediation effectiveness.

All claims and encounters associated with FWA are voided, and any money paid to excluded entities is returned to LDH per the instructions in the MCO Manual.

2.6.14.1.1 Any training programs that the Proposer uses to train employees, subcontractors, and providers on …

Our educational content emphasizes to our employees, providers, subcontractors and enrollees that they are on the front lines in deterring and detecting Medicaid FWA and are obligated to report suspicions of unethical or illegal behavior.

Training for Employees

Achieve Operational Excellence

Compliance and FWA training are required for all employees, managers and directors. All compliance and FWA-related training are completed within 30 days of hire and annually

thereafter. We monitor adherence by tracking training completion and notifying managers if employees do not complete training on time. Our compliance officer then follows up to verify training is completed by 100% of our staff. Training begins with the new employee orientation process, which is supplemented by organizational training courses relating to the Code of Conduct, Privacy and Security, and Conflicts of Interest. Specialized courses covering identification and reporting of suspected FWA, communication between employees and compliance, the False Claims Act, and Whistleblower Protection are required. Mandatory annual retraining requires an attestation and/or a passing test score.

In addition to mandatory training, our SIU investigators complete at least nine hours of investigations training each year**. In 2020, they each completed a total of 24 hours of additional specialized training.** Moreover, our compliance officer conducts annual training on Louisiana-specific contract requirements, including those in the Model Contract. The compliance officer shares relevant publications from LDH throughout the year via email blasts, Health Plan Advisories, and announcements of new legislation.

Training for Providers

We offer integrity and compliance training to providers through our secure provider website, *UHCprovider.com* (available 24 hours a day, seven days a week), such as correct coding education through "Coding Corner." We convey information about our FWA program in our *Care Provider Manual*, our provider newsletter *Practice Matters*, and through targeted provider education letters, with provider advocates conducting in-person training to providers and their staff as needed.

We promote the American Board of Internal Medicine (ABIM) Foundation's **Choosing Wisely** campaign, which is aimed at avoiding overutilization of inappropriate services by providing specific, evidence-based recommendations clinicians and enrollees can discuss, such as when tests and procedures (e.g., CT scans, antibiotics) may be appropriate and the process used for the recommendation. Providers have multiple venues for any questions or points of escalation, including provider expositions, a provider hotline outside the provider call center, our grievances and appeals process, and provider advocates who address issues through face-to-face interaction.

Our provider education program includes outreach to providers with aberrant billing patterns in a collaborative, respectful manner to minimize provider tensions. The goal is to remediate behavior that, if not corrected or addressed, could lead to a focused and potentially contentious audit in the future. We perform this analysis without payment delays or burdensome record requests. This approach allows us to influence billing practices through customized provider engagement, including letters, outreach via phone and one-on-one meetings with the provider and a certified professional coder. Providers receive a letter tailored to the claims experience from their practice and a report that demonstrates the results of their billing compared to their peers. Providers are encouraged to contact us through their field-based, regionally assigned provider advocate to discuss the results in more detail. We monitor the provider's behavior for improvement and, if none is identified, we consider outreach, audit, formal

More In-person Training for Providers than Ever Before

Having local provider advocates in all nine Louisiana regions prompts positive feedback, such as this from one of our provider's staff: "As coders, we are very excited about the proactive education initiatives being implemented. Any feedback related to coding will assist our auditors and educators to drill down further and provide effective education and feedback to our coders."
— Beth Mata, CPC,
LCMC Health

education or investigation as the next step. **In 2020, we submitted letters to 530 Louisiana Medicaid providers covering over 29 topics, the most prevalent being issues with unbundled billing.**

A specialized practice management team of licensed clinicians conducts systematic reviews of provider practices to identify atypical clinical patterns of behavior and determine if the behavior warrants intervention. The team may make announced or unannounced on-site field audits. Appropriate departments are informed of the identified patterns and then the team: reviews aberrant claims billing patterns with the provider; offers education on clinical and billing guidelines; conducts clinical audits with potential performance improvement plans or network termination; or refers the case to the SIU if they identify a prospective flag or recoupment opportunity. Typically, these activities lead to targeted education opportunities for providers.

Practice specialists in Louisiana made 193 referrals to the SIU since 2019.

Training for Subcontractors

Subcontractors are responsible for adhering to all compliance program elements outlined by federal and state regulations and UnitedHealthcare. These requirements are communicated via methods such as our dedicated website for subcontractors and our Annual Compliance Notice. Subcontractor Education Program elements include, but are not limited to:

- Federal and state laws related to an effective compliance program, which safeguards against improper payments and utilization of services, and methods of reporting FWA
- Distribution of code of conduct upon hire, and annually thereafter
- General compliance and FWA training upon hire, and annually thereafter
- OIG/GSA exclusion checks
- Offshoring limitations
- Monitoring and auditing
- Document retention for 10 years following the termination of the contract

2.6.14.1.2 How the Proposer engages enrollees in preventing fraud, waste and abuse;

Enrollees receive education upon enrollment, beginning with their welcome *HealthTalk* newsletter, which includes descriptions of FWA and instructions on how to report it. Their health plan and pharmacy ID cards include a telephone number to report tips, and our *Member Handbook* includes definitions of FWA, how to identify FWA (with examples), the enrollee's responsibility to prevent FWA, and ways to report FWA. Enrollees receive additional education through the Getting Started Guide, *HealthTalk* newsletter, behavioral health support website (*liveandworkwell.com*) and enrollee mobile application.

Materials encourage appropriate, cost-effective use of health care, including the importance of PCP prior authorizations, emergency care, annual checkups, value-added services, non-covered services and more. At our Member Advisory Committee meetings, our compliance officer presents topics related to FWA prevention, and our case managers and enrollee-facing staff support enrollees who may have experienced FWA by formally alerting our team to investigate. Enrollees can review claims through our enrollee website, *myuhc.com*, and contact us if they see evidence of FWA.

We promote the ABIM Foundation's **Choosing Wisely** campaign via literature provided at enrollee events and in-office provider signage. The campaign encourages enrollees to ask questions like:

- Do I really need this test or procedure?
- What are the risks and side effects?
- Are there simpler, safer options?
- What happens if I don't do anything?
- How much does it cost, and will my insurance pay for it?

The Code of Federal Regulations (42 C.F.R. §455.20, Recipient Verification Procedure), states that an agency must have a way to verify whether services billed by providers were received. UnitedHealthcare engages enrollees via letter to identify and report any suspicious activity. Any potential inconsistencies identified by the enrollees are further reviewed, investigated and reported, if warranted, within three days of notice that services were not received.

2.6.14.1.3 The data analytic algorithms that the Proposer will use for purposes of fraud prevention and detection;

We are efficient at detecting FWA, predictive modeling, electronic data analysis identifying aberrant and excessive billing practices and trends, inappropriate treatment, fictitious and unqualified providers, and fictitious and ineligible enrollees. We apply automated claim edits based upon correct coding, industry standards for HIPAA, state and federal regulations, UnitedHealthcare reimbursement, medical and drug policies, and specialty programs to validate claim payment and confirm consistent enrollee and provider experiences. Programs identifying potential FWA include:

Diagnosis to Drug Match (DX/Rx): A data analytics "drug to diagnosis" match, along with age edits, confirms appropriate medication use. This program identifies high-risk behavior, fraudulent schemes such as obtaining controlled substances, and high-cost supplies for unlawful distribution.

Coordination of Benefits Smart Utility: This program matches eligibility information from participating payers across the nation and provides the results to the payers weekly. This information is used to set flags on the adjudication platform.

Algorithm/Data Mining: UnitedHealthcare identifies evidence of overlapping coverage through resources such as eligibility data, enrollee communications, claims and prior authorization data.

Machine Learning: We use innovative machine learning (sometimes referred to as **advanced analytics**) to uncover unusual provider behavior. Incorporating numerous technologies that create algorithms as data is analyzed, it makes predictions when presented with new data sets. Our machine learning methods include neural networks, clustering, network analysis and graph theory.

Natural Language Processing (NLP): Another type of advanced analytics, NLP enables a computer program to understand spoken or written human language to read text, hear speech, and interpret unstructured data (electronic health records, medical records, claims data, and call center conversations) and place it into a usable structure. Using this data that would not be available without NLP, UnitedHealthcare can extract trends and identify root cause issues to combat FWA. NLP helps us prioritize leads with allegation details that include fraud trend key words. We employ NLP to identify trends in fraud referrals from external sources like OIG, DOJ, and news articles to identify subject areas of concern.

Pharmacy Drug Utilization Review (DUR) Program: The DUR program identifies high-risk, dangerous enrollee utilization patterns or gaps in care, looks at prescribing trends outside evidence-based guidelines for educational opportunities, and looks to alert pharmacies of medication-related issues they may not be aware of when an enrollee uses multiple pharmacies. This program detects potential high-risk activity or underlying substance use disorder. Our DUR program may then create a referral to the lock-in program, restricting an enrollee to a certain prescriber and pharmacy.

Pre-payment Flags: When we believe a provider has engaged in FWA, a prospective "flag" can be placed on the provider's payments to prevent payments to the provider until we validate their billing patterns and either create opportunities for provider education or investigate billing practices, reducing administrative costs. Both provider- and claim-centric prepayment flags identify "complex" cases for review.

Aberrant Billing Patterns (ABPs): We maintain libraries of ABPs that include queries and algorithms to identify suspected FWA based upon known or suspected schemes and practices. These ABPs include general queries and criteria applicable to all health plan claims and those tailored to common FWA schemes.

Claims Edits: Our clinical edit system identifies claims for "automated" reviews by analyzing physician health care claims based upon business rules, which automate reimbursement policy and industry standard coding practices. Our systems support health care reform mandates, including National Correct Coding Initiative (NCCI) bundling, medically unlikely event (MUE) and health care acquired conditions.

Clinical Pathways Transformation Investment in Action

When data analytics identified an internal medicine provider in Baton Rouge as an outlier for billing the new patient evaluation and management code 99205, we initiated a case investigation. Further analysis showed the provider billing a high volume for procedure code 99214 as well. Background research, an on-site inspection, a medical record review, and a provider interview revealed upcoding resulting in overpayments, and a settlement of $800,000 was reached with the provider.

2.6.14.1.4 Methods the Proposer will use to identify high-risk claims and its definition of "high-risk claims"; …

Our methods to identify high-risk claims range from individual provider monitoring to innovative software for automated data risk scoring. Many of the algorithms, detailed earlier, identify defined high-risk claims (e.g., durable medical equipment, home health aides, inappropriate use of medication, or high-cost supplies for unlawful distribution) and include, but are not limited to, pre-pay analytic edits, aberrant billing patterns, data mining and machine learning.

The schemes used in health care FWA prevention are continually evolving, and our definition of high-risk claims are those having non-negligible evidence of not being associated with legitimately provided services. We keep apprised of industry trends through participation in national organizations like the National Health Care Anti-Fraud Association and the annual HHS OIG report, which lists convictions and recoveries by various categories and our own claims analysis. Our dedicated Louisiana SIU manager and investigators discuss investigative schemes, findings, and actions related to similar investigative efforts during the monthly calls with LDH and provide information to attendees from various agencies, to include other MCOs and MFCU in Louisiana and other states.

2.6.14.1.5 The Proposer's experience with provider recovery collection.

While we are aggressive in our pursuit of resolving overpayments, we recognize that, at times, it may be complicated or difficult for providers, particularly as multiple MCOs can be recovering for the same issue at the same time. We work with providers to determine the most equitable manner possible for a successful resolution. We have a dedicated team who oversees retrospective recovery activities and handles all actions necessary to enable recovery of overpayments, which we base upon an established recovery process that includes:

- **Use of our Overpayment, Detection, and Recovery (ODAR) platform to process the affected claims.** Our team loads suspect claims to ODAR to confirm no other takebacks were affected by that claim. They then send them through ODAR for financial processing, and investigators produce the demand letters.
- **Health plan notification of the recovery opportunity.** Approval is required to proceed with the process, and if approved, we send overpayment demand letters to providers. In most cases, the turnaround time for provider response is 30 days.
- **Provider appeal.** Providers are entitled to file an appeal following state and LDH guidelines published in our *Care Provider Manual*.

Through our FWA program, **since 2014, we have recovered over $4 million and in 2020 alone, UnitedHealthcare recovered over $950,000 in LDH overpayments from providers, resulting from over 1,100 tips and investigations.** Together, investigators and negotiators work with providers to reach workable settlements. This maximizes recoveries and minimizes the need for litigation while allowing providers to maintain their business activities.

2.6.14.2 The Proposer should provide a detailed description of its capability to produce the required reports …

Ad Hoc Reports of FWA Incidents Involving Individuals or Entities

Achieve Operational Excellence

In compliance with the Model Contract, we report any FWA incident or notice concerning individuals or entities within three business days. Additionally, we report all credible allegations to LDH program Integrity using its Fraud or Notification referral forms. We immediately report provider fraud and abuse or enrollee fraud to LDH and local law enforcement and notify LDH immediately if we are contacted by any investigative authority. We check all required exclusion databases monthly. We check all state licensing boards and report, within three business days, any individuals or entities with sanctions in any state or line of business to LDH if there is Louisiana Medicaid exposure.

We will continue to report on overpayments from LDH to UnitedHealthcare, FWA in the administration of the Louisiana Medicaid program (within five business days), and FWA identified through the medical and pharmacy utilization management program. We also will begin reporting, upon receipt, any disclosure by a provider of overpayments in excess of $25,000 in accordance with all Model Contract requirements.

Standing Reports of FWA Activities

Continued submission of these reports includes our monthly reports on tips, audits and exclusion database review attestation; quarterly FWA audits and activities (becoming monthly) and verification of services; and annual reports of recoveries and overpayments and the FWA compliance program plan. We also will continue to provide monthly reports on unsolicited provider refunds in accordance with the Model Contract.

For both ad hoc and standing reports, we use our proprietary reporting software and databases and keep detailed tracking logs to support required reporting. Our reporting software (e.g., Serena Business Manager and PICTS) tracks and monitors tips, including those reported through the Recipient Verification of Services process. Another proprietary database, ODAR, tracks and reconciles claims payments, including reporting on unsolicited provider refunds. Our investigators log and track their cases and associated investigatory processes. This data, combined with PICTS and ODAR, forms the basis of our reports to the State on tips, audits and FWA activities.

2.6.15 Physical and Specialized Behavioral Health Integration Requirements [10-page limit]

2.6.15.1 The Proposer should provide a description of its fully integrated care model, inclusive of experience …

Our Fully Integrated Care Model

Elevate Integrated Care

With the addition of behavioral health to Healthy Louisiana in 2015, we developed our fully integrated, person-centered care model combining the principles of recovery and resiliency with evidence-based clinical practice. Built upon more than a decade of experience with integrated care models across the country, we understand our **enrollees' physical, behavioral and social needs are interconnected.** In Louisiana, **32% of our enrollees have comorbid medical and behavioral health needs** and face barriers to successful treatment and recovery. From 2017 to 2019, we increased this cohort's connection to outpatient behavioral health services by 12.9% while decreasing ED utilization by 4.3%. Only 34% of our primary care and behavioral health providers deliver integrated physical and behavioral care, so we draw on the strength of our successful quality, value-based payment, and provider support programs to drive integration and reduce fragmentation between delivery systems. We added **a Director of Care Integration, Ann Wilder,** in 2019 to lead our integration initiatives.

Louisiana Integrated Care Model
We currently manage the care of 157,860 Louisiana Medicaid enrollees diagnosed with both medical and behavioral health disorders representing:

- Medicaid enrollment – 32%
- Our enrollee expense – 61%
- ED visits – 62%
- Inpatient admissions – 75%

My Life's Best Work
"I do this work because I see both the personal and far-reaching benefits of improved communication between providers. The enrollee knows they are being seen, heard and valued — integration of care is the best foundation for success."

– Ann Wilder, LPC, LAC, Louisiana Director of Care Integration

To create a **seamlessly integrated enrollee care experience**, we provide convenient, reliable access to physical, behavioral and social care through:

- **Understanding** enrollee needs, using sophisticated, holistic and proven tools
- **Engaging enrollees** with a range of general and tailored supports aligned to the variety of risk levels and needs of our enrollee population
- **Partnering with providers** to promote access and support enrollees' integrated experience. Partnerships include targeted investments in our network to strengthen communities
- **Evaluating** our influence on enrollees' health outcomes to continuously refine our approach

Our care management model (detailed in Section 2.6.6 Care Management) identifies individuals who would benefit from program supports and offers episodic interventions to confirm enrollees have access to integrated holistic services. We use tiered case management to identify enrollees who may benefit from higher-touch approach that includes an integrated comprehensive assessment and individualized plan of care with regionally co-located staff trained to address whole-person needs.

Understanding Enrollee Needs with Analytics and Refined Tools

We use a variety of tools, algorithms and sources to understand enrollees' needs, including an integrated Health Needs Assessment (HNA), our Hotspotting tool, Impact Pro, and insights from our

network of PCPs and specialists. Our predictive analytics tools evaluate demographics, physical, behavioral, and pharmacy claims, social determinants of health (SDOH) indicators, in addition to more than 300 clinical indicators, to create Impactable Risk registries identifying enrollees with gaps in care, high utilization, risk markers and condition-specific triggering events. These registries indicate enrollees who have physical, behavioral and social needs, helping care managers identify which resources may be needed. **This holistic identification strategy results in enrollees with comorbid physical and behavioral health needs being engaged in case management at more than three times the rate of other enrollees.**

Integrated Engagement Opportunities for All Enrollees

All enrollees have access to immediate assistance 24 hours a day, seven days a week. For example, our NurseLine offers individuals, families and caregivers immediate and non-judgmental support and on-demand assistance for a full range of behavioral and health concerns. In addition, we have a **Behavioral Health Crisis Support Line** providing crisis assessment and triage services, and an SUD Helpline. Our enrollees will soon have access to **Sanvello**, a self-help digital application using clinically validated techniques (e.g., cognitive behavioral therapy and mindfulness) through smartphone interactive tools.

Customized Engagement to Meet Higher-risk Enrollee Needs

Enrollees with more complex needs are enrolled in our case management program. Our intensive **Integrated Care Pod (or "Pods")** help enrollees with the **highest needs** (i.e., Tier 3). Pods are field-based, interdisciplinary teams with a licensed nurse, licensed behavioral health advocate and CHW as needed. The enrollee's primary health concern determines whether a nurse or behavioral health advocate is lead case manager.

Pods are supported by a Louisiana-based Interdisciplinary Care Team (ICT) trained to collaboratively address physical, behavioral, SDOH, and pharmacy needs and include a physical health and behavioral health medical director, a housing navigator, recovery and resiliency manager, pharmacist and a peer support specialist. The ICT incorporates the PCP, provider-based case managers, behavioral health provider or specialist, pharmacist and other case managers as appropriate.

Peer Support Specialists (PSS)
Our peer support specialists use their lived experience to connect with our enrollees. All peers are trained to serve as whole health peer coaches to address integrated behavioral health recovery with comorbid chronic medical condition management. In 2018-2019, Louisiana PSS services resulted **in an 11.4% reduction in IP/ED costs and 12% reduction in OP/Physician spend.**

In 2016, we implemented peer support in Louisiana to assist enrollees with behavioral health and substance use disorders to promote recovery through living testimony and reinforce resilience and self-management. After witnessing the influence of our peer support specialist and the value they bring, we are adding peers and training them to provide whole health peer coaching in 2021.

Targeted Interventions to Address Specific Enrollee Needs and Increase Access

Through our years of experience in Louisiana's communities, we have developed an understanding of local needs and relationships with the local service providers to address those needs. We know 32% of our enrollees with co-occurring conditions drive 62% of our ED utilization. Based on this knowledge, we built a suite of services to allow enrollees to choose the access point that works for them to address both behavioral and medical needs.

Telehealth Directory Identifiers. We offer a comprehensive network of Louisiana-based providers for on-demand physical and behavioral tele-support available through our enrollee portal. **Over 12,500 providers** have delivered telehealth services to our enrollees since 2020. In Q4 2021, we will add an icon in our *Provider Directory* to indicate providers that offer telehealth.

Behavioral Health Virtual Visits. Our virtual visits platform, used by over 400 providers today, connects enrollees with a Louisiana psychiatrist or therapist using secure videoconferencing via smartphone, tablet or computer, or in a provider's office. Clinicians can evaluate and treat a spectrum of behavioral health conditions, provide therapy and prescribe medications, with some offering evening and weekend hours to increase access.

Acadian Ambulance. Providing a **toll-free line exclusive for UnitedHealthcare enrollees and providers,** Acadian Ambulance is available 24 hours a day, seven days a week. They provide an in-person visit to address a current condition when clinicians, NurseLine, and/or community health workers (CHWs) have determined the enrollee is not in acute distress or in need of emergency services. They can assess the enrollee and Treat in Place by initiating a telehealth visit or transport the enrollee to various care settings.

Ready Responders. This network of trained EMTs, paramedics and nurses visit high-risk, difficult-to-reach enrollees with inappropriate ED utilization including those with co-existing conditions. They connect enrollees to PCPs, specialists and telehealth consults to address their conditions. Since 2018, more than 2,500 enrollees have used Ready Responders, including over 1,900 enrollees with co-existing physical and behavioral health diagnoses. They monitor prescription adherence, evaluate risk factors for ED use, and counsel on appropriate health care service settings. We conduct weekly rounds with Ready Responders to discuss each enrollee's case and closing care gaps.

Provider Partnerships for Integrated Care

Our enrollees' experience depends on their interactions with providers, so we have developed both targeted partnerships and strategic investments to improve community infrastructure. Our leadership team selects opportunities based upon data analysis and enrollee needs. These investments address gaps in the delivery system and community needs detailed below and in Section 2.6.15.2.

Collaborative Provider Partnerships Enabling Integrated Enrollee Care

Implemented in 2020, **Reducing Admissions with Collaborative Interventions (RACI)** is an interdisciplinary approach to decrease acute behavioral health readmissions and increase community tenure for individuals with complex medical and behavioral needs. Through current partnerships with Brentwood Hospital, River Oaks Hospital, Covington Behavioral Health, and Odyssey House we demonstrated a 48% improvement in 30-day readmission rates, 30% improvement in 90-day readmission rates, and 18% improvement in 90-day community tenure.

We are implementing an **ED/IP MAT Initiation and Referral to Ongoing Care initiative** based upon American Society of Addiction Medicine-training for ED providers. This initiative includes value-based payment to encourage and reward outcomes and cross-continuum collaboration for connection to follow-up care after discharge. This new delivery model was informed by an analysis of our data showing 60% of our enrollees with opioid use disorder (OUD) have one or more hospital events each year, while virtually no hospitals initiate MAT when individuals are in their care.

We partner with **Eleanor Health,** a comprehensive provider of SUD treatment and wraparound services that offers same-day and next-day access to in-person or Louisiana-based virtual treatment. We are working with their on-the-ground Access Teams in Baton Rouge, Metairie, and soon Shreveport to proactively engage our highest needs enrollees, including pregnant women in need of addiction treatment, individuals in relapse seeking to reengage in their recovery process, and older adults who require more intensive medical support.

Investments to Address Community Gaps and Increase Provider Capacity

We work with our providers to build capacity to support the integrated needs of our enrollees. We funded over $1 million for our **FQHC Transformation Initiative, enabling** 15 Louisiana FQHCs to expand their local telehealth or digital engagement capabilities for delivery of physical and behavioral health services.

In August 2018, we provided a $1.2 million grant to Woman's Hospital to implement its **Guiding Recovery and Creating Empowerment (GRACE)** program for pregnant enrollees who have SUD. GRACE provides comprehensive case management and care planning from providers in obstetrics and addictive disorders. Enrollees receive a warm handoff to resources including addiction recovery treatment centers, MAT, and social services support resulting in **increased MAT uptake, 90% of participants connected to behavioral health counseling, and 50% decreased preterm birth rates and improved birth weights by an average of 1.35 pounds.**

UnitedHealthcare Catalyst™ establishes cross-sector collaboratives between community and health care partners to address community health needs. We made a **$250,000 investment** to establish a collaborative focused on physical/behavioral health/SDOH integration in Baton Rouge. Launched in 2020, our team convened the Open Health Care Clinic and trusted community-based partners, including Bet-R Neighborhood Market, One-Stop Homeless Service Center, and Top Box Foods, to reach over 150 predominantly Black households with housing, utility, food and transportation assistance. Knowing over 80% of our enrollees experiencing homelessness have behavioral health needs, the Catalyst™ funds a dedicated behavioral health case manager at the One-Stop Homeless Service Center. An **additional $350,000** will be disbursed in late 2021 to launch a Catalyst™ with the New Orleans Housing Authority.

> "The opportunity to work with UnitedHealthcare through the Catalyst collaborative program is a game changer for our efforts to integrate primary care and behavioral health care. The value this program adds to the medical and behavioral health services we provide is immeasurable."
>
> *— Jamie, Open Health Care Clinic*

Evaluating Our Care Model's Success

Our proven programs with over 19,000 case management engagements since May 2018 have shown an average **19% decrease in total cost of care, 32% decrease in inpatient admissions and 27% decrease in ED visits**. We improved the quality of care for enrollees with behavioral health needs, with year-over-year improvements in both acute phase and continuation phase Antidepressant Medication Management every year since 2017. This includes a 6% improvement in both measures in 2020, following creation of our behavioral health outpatient shared savings model. This model improved antidepressant medication adherence by 14.8% for enrollees receiving care from participating providers.

Strategy for Training and Education

Our employee training is focused on **operational excellence, diversity and inclusion, person-centered care, health equity and system transformation,** and complies with federal mental health parity requirements. Upon hire, all employees receive the following training pertaining to the delivery and management of services, inclusive of several evidence-based practices

- Contractual covered benefits, value-adds benefits, and eligibility
- Mental health parity
- Diversity and inclusion
- Recognizing and addressing medical and behavioral health crises
- Appeals, complaints and grievances
- Pharmacy inquiries
- Trauma-informed care
- Motivational interviewing
- Recovery and resiliency principles
- Prochaska's stages of change
- Person-centered, integration concepts and practices
- Level of care and clinical practice guidelines

We train all enrollee-facing staff and validate an understanding of covered services, value-added benefits, and provider search capabilities including identification and referral to preferred providers, telehealth, and Express Access network. We conduct an annual survey among cross-department staff to assess organizational behavioral, physical, and SDOH integration and collect feedback on education/training needs. Our most recent survey showed an improvement in education since the 2019 survey and identified a need for expanded SDOH training, which is being added to our training opportunities. Training are mandatory and tracked in our educational system..

In 2020, we established the **Diversity, Inclusion and Racial Equity (DIRE) Committee** to lead employee training on health equity.

Provider training is available in-person from Clinical Consultants or through our provider portal with access to CME/CEU and non-CME/CEU courses on subjects such as: Behavioral Health Identification, Treatment and Referral in Primary Care, Advancing Complex Care Philosophy: Tools for Healing-centered Care, Trauma-informed Care and Cultural Competency. These tools and training are available 24 hours a day, seven days a week to enhance provider convenience and practice workflow. During provider orientation, all practitioners receive training in areas that address the delivery and management of services, including:

- Covered and Value-added benefits
- Access to care standards
- Level of care and clinical practice guidelines
- Authorization process
- Appeals and grievances
- Available on-demand resources

Mental Health Parity (MHP) Requirements and Related Training Activities

As strong advocates of parity for mental health and SUD benefits, we offer access to behavioral health care without barriers. Our financial and clinical models align with the Mental Health Parity and Addiction Equity Act of 2008 and the subsequent Final Rules for Medicaid. Training is provided to all employees, directors or other governing body enrollees, agents and other representatives engaged in functions subject to MHP. We educate applicable staff on MHP requirements annually and as part of new hire onboarding, with attestation required upon completion. In addition, our regional provider

advocates share parity educational resources with providers during provider outreach and education visits, and MHP training is available through our provider portal.

2.6.15.2 The Proposer should include how the following elements will be accomplished in its description:
2.6.15.2.1 Enhancing detection and treatment of behavioral health disorders, including risk of opioid dependence …

Enhancing Detection of Behavioral Disorders in Primary Care Settings

PCPs play a vital role in integrated care, as they are often the first contact for enrollees with behavioral health needs. In Louisiana, we know uncertainty regarding behavioral health treatment options is a common reason PCPs avoid screening. Our strategy includes training and resources on identification, treatment options, incentives and analytics to help address these concerns.

In 2021, UnitedHealthcare launched an incentive program offering an enhanced payment for physicians completing the early developmental screening. Beginning in 2022, we will implement an incentive program for PCPs to encourage behavioral health screening and diagnosis.

We focus on ensuring providers have the knowledge and tools they need to screen for and treat behavioral health conditions. Core components to our approach include:

- At orientation and through ongoing visits, we inform providers about our **Behavioral Health Toolkit for Medical Providers**, featuring screening tools, checklists, best practices, and Clinical Guidelines such as the *Comorbidities Job Aid to Support Integrated Health Care*.
- Our provider advocates **connect PCPs to referral and consultation resources**, including telehealth-enabled behavioral health providers and telemedicine for SUD care.

We provide reporting and analytics to support our PCPs. For example, we implemented multiple pharmacy strategies to help providers identify risk of opioid dependence, limit exposure and decrease risk. Using automated review triggers, our retrospective **DUR Abused Medication program** monitors utilization and alerts prescribing providers of enrollees whose use patterns could indicate overuse and abuse (e.g., excessive refills, therapeutic duplications). We provide annual reports on prescribing behavior compared to peers, including their rates on high-dose opioids, extended duration opioids and co-prescribing opioids with benzodiazepines.

We have seen continuous improvement in our prevention efforts, including lowering the percentage of first-time opioid prescriptions **of greater than 50 morphine mg equivalents to less than 5%.**

Supporting Treatment of Behavioral Health Conditions in Primary Care

Collocation with behavioral health providers is a powerful strategy for treating behavioral conditions in primary care settings. In August 2021, we provided **financial support** for Pediatric Associates of Denham Springs to **co-locate behavioral health services via telehealth**. Going forward, we will support rural PCPs by deploying 100 tablets to allow their patients to access tele-psych while in provider offices. This solution solves capacity issues for those without sufficient access to broadband throughout Louisiana. **Every time they meet with PCPs**, our provider advocates and clinical consultants ask if they have the necessary for common behavioral health conditions.

2.6.15.2.2 Coordination of care for enrollees with both medical and behavioral health disorders, including …

Coordination of Care for Enrollees with Physical and Behavioral Health Disorders

We closely track enrollee utilization to anticipate transitions, and we deploy care management resources and partner with providers to confirm effective coordination of care and data sharing.

Hospital Care Transition Team (HCT)
To date, our facility-embedded HCT has:

- Touched 8,932 cases
- Achieved 62.5% engagement

Since May 2018, we have engaged over 10,000 enrollees with physical and behavioral health needs in our case management programs. Our team-based care model, engaging each enrollee's ICT, allows a holistic view of the enrollee's needs. Our integrated Risk Screening Tool and Readmissions Predictive Model tools help us understand enrollee medical, behavioral, social and environmental risk factors to transition to outpatient settings. For those who are hospitalized, our dedicated Hospital Care Transition team provides comprehensive on-site discharge planning in collaboration with hospital staff..

For enrollees with behavioral health needs, such as those transitioning into/from residential facilities, we offer Transitional Care Management (TCM). Since May 2018, 4,215 enrollees with both physical and behavioral health needs have been engaged in TCM, experiencing an average **42% reduction in admission rate** after engagement. This includes creating an interdisciplinary plan of care before discharge, an in-person or telephonic assessment of the enrollee's integrated needs, and follow up to verify services are in place within seven days of the enrollee's transition. PCPs and behavioral health specialists are actively engaged in TCM.

Our utilization management team works with providers to accurately document medical necessity, level of care, crisis planning, and plans to verify treatment settings can address specific needs. Our **RACI** program is an interdisciplinary approach for decreasing acute behavioral health readmissions and increasing community tenure for individuals with complex needs. It supports provider communication and has shown reduced behavioral health admission rates and increased community tenure.

For all transitions, we facilitate a warm hand-off. We offer Care Angel, an AI-powered Virtual Nurse Assistant service that calls members transitioning from hospital to home to confirm post-discharge appointments are made and to check on discharge instructions or symptoms, escalating to a nurse as needed. Other supports include arranging non-emergency medical transport and leveraging our value-adds such as Mom's Meals and for our enrollees in our DOJ target population, our **Transitional Support Flex Fund**, which provides non-covered Healthy Louisiana services such as meal delivery, furniture and utility deposit.

2.6.15.2.3 Offering incentives and tracking progress for providers to help build greater care coordination, …

Incentives and Tracking Progress for Integrated Care

Our value-based payment offerings include several incentives designed to help providers take **their next step toward integrated care**. Incentives are aligned to our population health strategy and include select quality metrics focused on the value of integrated care.

Our **Gap Closure program** pays PCPs quarterly for each HEDIS® gap closed. By including the Follow-up After Emergency Department Visit for Mental Illness (since 2020) and Follow-up After Hospitalization for Mental Illness (since 2019) measures in this program, we incent PCPs to be

actively involved in their patient's behavioral health care. In 2020, we had 743 PCPs in the program, which increased in 2021 to 825 PCPs. In 2022, we will introduce additional **behavioral health care coordination incentives** for select providers.

We will bring our **Integrated Behavioral Health Home** (IBHH) program to Louisiana in 2022, focusing on enrollees with complex behavioral health needs and at least one chronic medical condition. Eligible providers can earn a lump sum incentive by lowering the total cost of care (TCOC) and meeting quality metrics. We recently implemented IBHH in our Texas and Florida programs, with more than an **8% reduction in ED utilization, IP admits and all-cause readmissions**.

Our **Integrated Shared Savings** model, launching with the Louisiana Primary Care Association in 2022, supports providers with an integrated medical and behavioral clinical model. Providers can share in savings they achieve against TCOC metrics. Practices must meet a quality gate for these measures, which align with LDH quality and performance measures.

To track progress and empower providers, we provide a suite of comprehensive, tailored reporting packages and scorecards. Our clinical consultants meet with providers regularly to provide practice coaching and make certain they have the resources to be successful.

Integrating Social Care into Physical and Behavioral Health Settings

Elevate Integrated Care

Enabling our providers to address SDOH effectively is key to our integrated provider support strategy. In April 2021, we launched an initiative to educate providers on the use of PRAPARE, an evidence-based assessment tool to identify SDOH needs. When providers identify needs, we encourage them to refer to community resources and provide an additional payment for closing the referral loop with follow-up documentation in the enrollee's chart within 30 days.

2.6.15.2.4 Offering tools, guidance and financial incentives to help improve behavioral health and physical …

Provider Support for Behavioral Health and Physical Health Integration

By working with providers across Louisiana and participating in the LDH's MCO Integration Assessment, we know providers' current capacity for integrated care varies greatly. While some already schedule joint appointments and leverage integrated records, others struggle with screening and referrals. Key barriers include **limited technology, lack of interdisciplinary relationships, provider confidence or interest, staff training and financial resources. Our approach includes tools, guidance and financial incentives** designed to address those barriers for physical and behavioral health providers at any level of integration.

Working Together through EII

"When Janeace reached out to me asking if we would be interested in this pilot program, I realized that voicing my concern regarding the real pandemic in pediatrics being mental health was heard...I look forward to hopefully paving the way for how practices and insurance providers can come together for the best interest of the patients they both serve."

– Blaire Arceneaux, Pediatric Associates of Denham Springs

In 2019, we launched the **Enhanced Integration Initiative** (EII). Our clinical consultants meet with physical and behavioral health providers to assess their level of integration using the IPAT, set goals for increased integration, identify barriers and create action plans to move up the integration continuum. We have introduced EII to 16 providers across the State. **Based on positive provider feedback, we are committed to expanding this initiative to reach 150 providers in 2022.**

Integration Tools

We are developing **enhancements to our CommunityCare portal** to help PCPs and behavioral health providers **conveniently develop shared care plans**. To drive technology engagement, we will proactively outreach to behavioral health providers to collaborate with PCPs, assisting in obtaining required releases of information. Our clinical consultants and interdisciplinary teams, with experience designing collaborative care plans, will provide education on the effective use of this tool.

For providers seeking to collocate services via telehealth, **we will provide our virtual visits platform free of charge.** With over 400 behavioral health providers already participating in this program, we empower PCPs to **schedule joint appointments** and address clinician shortages in rural areas. This platform was essential during the COVID-19 public health emergency, contributing to a dramatic increase in telehealth utilization. The number of enrollees receiving telehealth care grew from under 2,000 in 2018 to over 37,000 in 2020 and will increase again in 2021.

Integration Guidance

In addition to the intensive coaching and support through the EII, physical/behavioral health providers receive training from our clinical consultants on care coordination and continuity of care. Because relationships are essential to integrated care, we will offer **joint regional training sessions to promote interdisciplinary relationship building**. Our training promotes the evidence-based practice of Screening, Brief Intervention and Referral to Treatment (SBIRT), especially for pregnant enrollees. Since 2018, we have seen a **600% increase in SBIRT procedures**.

To promote improved awareness of local resources and form collaborative relationships, our provider advocates educate providers on using **our *Provider Directory* to expand their referral network.** Our **Behavioral Health Toolkit for Medical Providers and Comorbidities Job Aid** are available through our provider portal with convenient access to **screening tools and treatment best practices**.

Financial Incentives for Integration

In 2022, we will provide financial incentives for behavioral health care coordination to certain PCPs participating in our Gap Closure program. These incentives will compensate providers who deliver integrated care, including systematic assessment and monitoring of enrollees' behavioral health condition, joint care planning and facilitation and coordination of behavioral health treatment. Our clinical consultants will make certain providers have tools and training to deliver these services.

2.6.15.2.5 Identifying those who use ED services to assist in scheduling follow-up care with PCP and/or …

ED Follow-Up Care

We identify enrollees using ED services via admission-discharge-transfer (ADT) data and claims-based methods like HealthView Analytics and our Hotspotting tool. We assist in connecting enrollees to follow-up care through case management, innovative partnerships that expand access to ambulatory care, and provider incentives that promote ED follow-up care.

ED Navigator Helps Enrollees Avoid Unnecessary ED Utilization
Comparison to a matched control group indicates our ED Navigator reduces ED visits by 30%.

Our **ED Navigator** uses ADT data to identify enrollees in near real-time, prioritizing those with a pattern of high non-emergent utilization. The ED Navigator then works with ED staff to coordinate follow-up care.

Enrollees with frequent ED utilization are identified for engagement in high-risk case management (Tier 2 or 3) by our Integrated Care Pods. They receive assistance with scheduling appointments with their PCP and behavioral health specialists. Our staff follow up with enrollees to verify appointments are kept.

Medication-assisted Treatment in the ED: For enrollees with OUD who present in participating EDs, hospital staff initiate MAT and schedule follow up with outpatient MAT providers. Our peer support specialists serve as guides and companions on their road to recovery.

For those with SUD or behavioral health needs, access teams from **Eleanor Health** in Baton Rouge and Metairie (and soon Shreveport) will proactively engage enrollees at discharge from ED, inpatient and residential facilities. Eleanor provides same-day and next-day access to in-person or virtual treatment and coordination of physical/behavioral health services with the enrollee's PCP.

We incent primary care providers to proactively coordinate follow-up care for enrollees who use the ED for mental illness or SUD through our PCP Gap Closure model for Follow-up After Emergency Department Visit for Mental Illness HEDIS® measure.

2.6.15.2.6 Ensuring continuity and coordination of care for enrollees who have been screened positive in their …

Continuity and Care Coordination

Information gathered through our comprehensive assessment, an HNA or assessments performed by providers, including the Physicians Health Questionnaire-9, Generalized Anxiety Disorder-7, Short Post Traumatic Stress Disorder Rating Interview, DAST-10, Pediatric Symptom Checklist, CRAFFT, and Columbia Suicide Severity Rating Scale conducted by PCPs and behavioral health providers serve as the foundation of continuity of care and coordination for our enrollees. Our Pods coordinate care, including short-term and long-term goals, scheduling and confirming appointment(s), medication adherence, and identifying and removing barriers to treatment while remaining in contact to mitigate complications. If inpatient services are necessary, discharge planning for medical and behavioral health services will begin upon admission.

Our case managers support providers who identify needs through their screening processes and assist with referrals as needed. We offer a "No Wrong Door" approach for providers who need support getting their patient to the correct provider. Whether a provider calls into the provider services center or sends an email, our "No Wrong Door" team does the legwork of reaching out to specialists to confirm at least three options in network, accept new referrals and provide tentative appointment options to the provider and enrollee.

For enrollees who require significant behavioral health services, the ICT may include a peer support specialist trained to serve as a whole health peer coach, providing hands-on support, including attending appointments. The RN, behavioral health advocate, and whole health peer coach will jointly verify all needed services are available and the behavioral health services are coordinated with the enrollee's medical services.

4.4. Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs Participation

4.4.1

If a Proposer is not a certified small entrepreneurship as described herein, but plans to use certified small entrepreneurship(s), Proposer shall include in their proposal the names of their certified Veteran Initiative or Hudson Initiative small entrepreneurship subcontractor(s), a description of the work each will perform, and the dollar value of each subcontract.

Our Commitment to Economic Development and Veteran Hudson Initiative Programs

As one of Louisiana's largest contractors in the Medicaid Managed Care Program serving the needs of more than 500,000 enrollees, we are committed to supporting LDH's efforts to increase state purchasing and contracting opportunities available to certified Louisiana-based small entrepreneurship businesses under the Louisiana Veteran and Hudson Small Entrepreneurship Initiatives ("Certified Businesses"). Delivering high-quality services to the residents of Louisiana by investing in the local business community, we contribute to overall economic growth and expansion through job creation, wages and tax revenue and deepen our footprint and commitment to the communities we serve.

We have a strong history of using Veteran's and Hudson entities, spending over $20 million over the past five years with previous and current certified businesses. We plan to remain committed to these partners while expanding to include additional businesses over the next three-year commitment.

Additionally, in support of expanding the certified business base and helping small and veteran businesses build back after a challenging 2020, we will identify opportunities to use our enterprise resources to raise awareness of the certification program through promotion and marketing to educate local businesses on the benefits and value of becoming certified themselves, if applicable, or using these businesses in their operations.

[redacted] By engaging with these certified businesses upon contract award, we will make sure certified Louisiana-based businesses deliver services related to the Medicaid Managed Care Program when possible. These services include, but are not limited to:

- Care transitions
- Home health care
- Pediatric day health center
- Retail pharmacy
- Durable medical equipment (DME)
- Rehabilitation
- Non-emergency medical transportation (NEMT)
- Wound care management
- Wellness
- Physical therapy/occupational therapy
- Marketing/advertising
- Printing
- Recruiting/staffing

4.4.2

Twelve percent (12%) of the total evaluation points in this RFP are reserved for Proposers who are certified small entrepreneurships, or who will engage the participation of one or more certified small entrepreneurships as subcontractors. Reserved points shall be added to the applicable Proposers' evaluation score as follows:

4.4.2.1 If the Proposer is a certified Veterans Initiative small entrepreneurship, the Proposer shall receive points equal to twelve percent (12%) of the total evaluation points in this RFP.

4.4.2.2 If the Proposer is a certified Hudson Initiative small entrepreneurship, the Proposer shall receive points equal to ten percent (10%) of the total evaluation points in this RFP.

4.4.2.3 If the Proposer demonstrates its intent to use certified small entrepreneurship(s) in the performance of contract work resulting from this solicitation, the Proposer shall receive points equal to the net percentage of contract work which is projected to be performed by or through certified small entrepreneurship subcontractors, multiplied by the appropriate number of evaluation points. For Louisiana Veteran and/or Hudson Initiative evaluation purposes only, the estimated three-year contract amount will be eight billion dollars;

4.4.2.4 The total number of points awarded pursuant to this Section shall not exceed twelve percent (12%) of the total number of evaluation points in this RFP.

4.4.2.5 If the Proposer is a certified Veterans Initiative or Hudson Initiative small entrepreneurship, the Proposer must note this in its proposal in order to receive the full amount of applicable reserved points.

4.4.2.6 If the Proposer is not a certified small entrepreneurship, but has engaged one (1) or more Veterans Initiative or Hudson Initiative certified small entrepreneurship(s) to participate as subcontractors, the Proposer shall provide, as an attachment to their proposal using the Hudson and Veterans Initiative Response Template provided in the

procurement library, the following information for each certified small entrepreneurship subcontractor in order to obtain any applicable Veterans Initiative or Hudson Initiative points:

- Subcontractor's name;
- A detailed description of the work to be performed; and
- The anticipated dollar value of the subcontract for the three-year contract term.

Please see Attachment 4.4.2.6 Hudson and Veteran Initiative Response Template.

4.4.3

The Proposer may submit this information in electronic format in lieu of hard copy. The electronic version of this attachment should be in Excel format. This attachment is exempt from the total page limit. Note – it is not mandatory to have a Veterans Initiative or Hudson Initiative certified small entrepreneurship subcontractor. However, it is mandatory to include this information in order to receive any allotted points when applicable.

Please see Attachment 4.4.2.6 Hudson and Veteran Initiative Response Template.

4.4.4

If multiple Veterans Initiative or Hudson Initiative subcontractors will be used, the above required information should be listed for each subcontractor. The Proposer should provide a sufficiently detailed description of each subcontractor's work so the Department is able to determine if there is duplication or overlap, or if the subcontractor's services constitute a distinct scope of work from each other subcontractor(s).

Please see Attachment 4.4.2.6 Hudson and Veteran Initiative Response Template

Subcontractor Information			
Subcontractor Name	Hudson/Veteran	Description of Work	Subcontract Value

[redacted]

Subcontractor Information			
Subcontractor Name	Hudson/Veteran	Description of Work	Subcontract Value
[redacted]			

Subcontractor Information			
Subcontractor Name	Hudson/Veteran	Description of Work	Subcontract Value

[redacted]

Subcontractor Information			
Subcontractor Name	Hudson/Veteran	Description of Work	Subcontract Value
[redacted]			

Subcontractor Information			
Subcontractor Name	Hudson/Veteran	Description of Work	Subcontract Value
[redacted]			