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Company Examinations

Report of Examination

of

UNITED HEALTHCARE OF TENNESSEE, INC.

as of

December 31, 2004

PARTICIPATION

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DEPARTMENT OF COMMERCE AND INSURANCE
STATE OF TENNESSEE
Nashville, Tennessee

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STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
INSURANCE DIVISION
500 JAMES ROBERTSON PARKWAY - 4TH FLOOR
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April 27, 2006

The Honorable Paula A. Flowers
Commissioner
Tennessee Department of Commerce and Insurance
500 James Robertson Parkway, 5th Floor
Nashville, Tennessee 37243

The Honorable Alfred W. Gross, Chairman
Financial Condition (E) Committee, NAIC
Commissioner of Insurance,
Virginia Bureau of Insurance
State Corporation Commission
1300 East Main Street
Richmond, Virginia 23219

The Honorable Eleanor Kitzman
Secretary, Southeastern Zone, NAIC
Commissioner of Insurance
South Carolina Department of Insurance
300 Arbor Lake Drive, Suite 1200
Columbia, South Carolina 29223

Commissioner Flowers, Commissioner Gross, and Commissioner Bell:

Pursuant to your instructions and in accordance with Tennessee statutes and regulations, and resolutions adopted by the National Association of Insurance Commissioners ("NAIC"), a financial examination has been made of the condition and affairs of

United Healthcare of Tennessee, Inc.
10 Cadillac Drive, Suite 200
Brentwood, Tennessee 37027

("the Plan") as of December 31, 2004, and the report thereon is hereby respectfully submitted.

SCOPE OF EXAMINATION

This examination commenced June 15, 2005, and covers the period from December 31, 2000, the date of the last examination, through December 31, 2004, in accordance with statutes, rules and procedures of Tennessee, the plan's domiciliary state. The examination was conducted at the Plan's office, located at 10 Cadillac Drive, Brentwood, Tennessee, 37027. This examination was conducted by duly authorized representatives of The Tennessee Department of Commerce and Insurance ("TDCI").

Location of Books and Records:

The Plan maintains it's Charter, bylaws, corporate minutes, investment records, reinsurance contracts and some correspondence files at 9900 Bren Road East, Minnetonka, Minnesota. The Plan retains its bank statements, accounting records, statutory statement records, underwriting, marketing, some correspondence and some policy issuance files at 5901 Lincoln Drive, Edina, Minnesota, 55436. The Plan's claim runs are stored electronically and retained at 450 Columbus Boulevard, Hartford, Connecticut 06103. However, claims records are available electronically at all United Healthcare Group Incorporated ("UHG") locations. The Plan's provider contracts are located at 10 Cadillac Drive, Brentwood, Tennessee 37027 and 2717 North 118th Circle, Omaha, Nebraska 68164. The Plan's policy files are maintained at 4316 Rice Lake Road, Duluth, Minnesota 55811, 408 North Cedar Bluff Road, Knoxville, Tennessee 37923, 633 Chestnut Street, Chattanooga, Tennessee 37450, 871 Ridgeway Loop Road, Memphis, Tennessee, 38120 and 10 Cadillac Drive, Brentwood, Tennessee 37027. The remainder of the correspondence files are located at 450 Columbus Boulevard. Hartford, Connecticut 06103 and North Keller Road, Maitland, Florida 32751. The remainder of the

policy issuance files are located at 4316 Rice Lake Road, Duluth, Minnesota 55811, 408 North Cedar Bluff Road, Knoxville, Tennessee, 633 Chestnut Street, Chattanooga, Tennessee 37450 871 Ridgeway Loop Road, Memphis, Tennessee 38120 and 10 Cadillac Drive, Brentwood, Tennessee, 37027.

The examination of the financial condition was conducted in accordance with guidelines and procedures contained in the NAIC Examiners Handbook. During the course of the examination, all assets and liabilities contained in the financial statements of this report were determined or estimated as of December 31, 2004. The degree of emphasis necessary for each item was determined by the examiner-in-charge during the planning stage of the examination. Test checks were made of income and disbursement items for selected periods, and a general review was made of the Plan's operations, practices, and compliance with applicable Tennessee statutes and regulations

An examination was also made into the following matters:

- Status of Prior Examination Findings
- History of the Plan
- Charter and Bylaws
- Management and Control
- Agreements with Parent, Subsidiaries and Affiliates
- Corporate Records
- Statutory Deposits
- Fidelity Bond and Other Insurance
- Excess Loss Insurance
- Territory and Plan of Operation
- Growth of the Plan
- Loss Experience
- Employee Welfare
- Litigation, Contingent Liabilities and Regulatory Action
- Dividends to Stockholder
- Subsequent Events
- Accounts and Records
- Financial Statement

This report is written by exception, except for certain items of regulatory significance. Those items examined and found to be substantially in compliance with statutes will not be commented on further.

The Plan is audited annually by an independent accounting firm ("auditors"). The auditors are part of the audit conducted for the holding company system of which the Plan is a member. The auditors' workpapers for the year ended 2004 were made available to

the examiners during the planning phase of this examination. Workpapers of the auditors' substantive testing, auditors' documentation of the Plan's procedures and verification of internal controls were relied upon where sufficient for the purposes of this examination. Copies of these workpapers are included in the examination workpapers where applicable.

The annual statements for the years ending December 31, 2001, 2002, 2003 and 2004 were reviewed and reconciled to the Plan's books.

Status of Prior Examination Findings

The previous examination of the Plan was made as of December 31, 2000 by TDCI examiners. The report on the examination was dated March 22, 2002, and covered the period from January 1, 1997 through December 31, 2000. The exception and recommendations made in the preceding Report on Examination dated March 22, 2002, and the corrective actions taken by the Plan are as follows:

Recommendations:

(1) "The Department's records at December 31, 2000 reflect a portion of the Plan's statutory deposits to be a $100,000 FNMA REMIC bond. The Plan sold this bond in 1992, but did not notify the Department of the sale. It is recommended that the Plan inform the Department of changes in its statutory deposits on a timely and accurate basis to ensure continuous compliance with TCA 56-32-212(b)."

Corrective Action: For the current period under review, the Plan complied with the recommendation and informed TDCI of changes in its statutory deposits on a timely and accurate basis to ensure continuous compliance with Tenn. Code Ann. § 56-32-212(b).

(2) "One of the Plan's provider contracts and the appendices of another contract were not listed as filed and approved by the Department. It is recommended that the Plan file all of its provider agreements, and any subsequent amendments or appendices thereto, with the Department in accordance with Tennessee Regulation 0780-1-28-.06."

Corrective Action: No conclusion can be made regarding this prior recommendation from the previous financial examination since a separate market conduct examination is ongoing as of the date of this report.

(3) "Minor discrepancies were noted in the Plan's application of the filed rating methodology for large groups, some of which were due to typographical errors in the rate

filings. It is recommended that the Plan file and apply its rating methodologies in accordance with TCA 56-32-207(b)."

Corrective Action: No conclusion can be made regarding this prior recommendation from the previous financial examination since a separate market conduct examination is ongoing as of the date of this report.

(4) "It appears that the Plan is not in strict compliance with the claims payment time guidelines stipulated by TCA 56-7-109. It is recommended that the Plan continue to endeavor to pay claims in accordance with TCA 56-7-109."

Corrective Action: No conclusion can be made regarding this prior recommendation from the previous financial examination since a separate market conduct examination is ongoing as of the date of this report.

(5) "Several errors and omissions were noted in the Plan's 2000 Annual Statement. It is recommended that the Plan comply with TCA 56-1-501(b) which requires that an annual statement be completed and filed in accordance with annual statement instructions established by the commissioner.' TCA 56-32-208 requires that this report be filed 'on the blank prescribed by the National Association of Insurance Commissioners for health maintenance organizations."

Corrective Action: For the current period under review, the Plan has partially complied with the recommendation. However, the Plan continues to report its premium receivables as a net asset on page 2 of the 2004 annual statement. Pursuant to the *NAIC Annual, Statement instructions*, the receivables should be reported gross and adjusted by the non-admitted portion reported in Exhibit 2, column 6 which is reflected as non-admitted on page 2. Furthermore, the Plan did not fully disclose the aging and non-admitted assets in Exhibit 2 as required by Tenn. Code Ann. § 56-32-208 and Tenn. Comp. R. & Regs., 0780-1-28.01. This is further discussed in this report in the sections marked "Analysis of Changes in Financial Statement, Comments Resulting From Examination" and "Recommendations".

HISTORY OF THE PLAN

The Plan was incorporated on September 17, 1990, as a for-profit corporation under the provisions of the Tennessee Business Corporation Act and was organized as a health maintenance organization ("HMO") pursuant to Tenn. Code Ann.§ 56-32 for the purpose of providing managed health care services to residents of Tennessee. The Plan

was issued a Certificate of Authority by the TDCI, effective September 13, 1991, to transact business in the State of Tennessee and commenced business on January 1, 1992. The current Certificate of Authority issued by the TDCI is dated January 26, 2001, and is valid until suspended or revoked.

The Plan was originally named "Complete Health of Tennessee, Inc." and was located in Birmingham, Alabama. Its principal offices were moved to Nashville in 1996 and Brentwood in 2000.

At its incorporation in 1990, the Plan was initially authorized to issue 2,000 shares of common stock, with each share to have a par value of one cent ($0.01). All shares were issued to the Plan's sole shareholder, Complete Health Services, Inc. ("CHS"). Share certificate number two (2) was issued September 11, 1991, reflecting a change in par value of the stock to $50 per share. The Plan states that share certificate number two (2) was issued in error; therefore, it was cancelled on February 10, 1998.

Effective May 31, 1994, CHS was acquired by UHG, formerly United HealthCare Corporation. Pursuant to the terms of the "Agreement and Plan of Merger" dated January 19, 1994, between UHG, UHC Red Acquisition, Inc. and CHS, UHC Red Acquisition, Inc. was merged with and into CHS, with CHS being the surviving entity. CHS is a wholly-owned subsidiary of UHG. To reflect the new affiliation, CHS changed its name to United HealthCare South, Inc. ("UHC South") on September 1, 1995.

UHC South changed the Plan's name to United Healthcare of Tennessee, Inc. on May 1, 1996.

On April 30, 1996, United HealthCare Services, Inc. ("UHCS"), an HMO management corporation and wholly-owned subsidiary of UHG, purchased UHC South from UHG.

On December 31, 1996, HealthWise of Tennessee, Inc. was purchased by UHC South from HealthWise of America, Inc., another wholly-owned subsidiary of UHG. On that same day, UHC South merged HealthWise of Tennessee, Inc. into the Plan, with the Plan being the surviving entity. As a result of this merger, the Plan's Paid in Surplus increased by $1,500,000

On January 2, 1998, UHC South merged with and into its parent, UHCS. Thus, UHCS became the sole shareholder of the Plan. Consequently, on February 10, 1998, stock certificate number three (3) was issued by the Plan to UHCS. This stock certificate

was issued for 2000 authorized shares of common stock at $50 par value per share. This certificate was cancelled June 30, 2000, when stock certificate number four (4) was issued for all outstanding shares to United HealthCare, Inc. ("UHCI"), a newly-formed Delaware subsidiary of UHCS. UHCI is the Plan's immediate parent.

A summary of the Plan's capitalization since inception is presented as follows:

Transaction Date	Number of Authorized Shares	Par Value	Shares Issued and Outstanding	Paid in Capital (Common Stock)	Paid in Surplus	Year End Fund Balance
1991	2,000	$50	50	$ 100,000	$430,000	$(366,312)
1992					720,000	(800,163)
1993						(834,207)
1994					200,000	299,616
1995						1,835,296
1996					8,500,000	
1996					1,500,000	(10,526,145)
1997					9,000,000	(13,292,424)
1998					10,850,084	(24,487,875)
1999					6,500,000	(26,632,230)
2000						(25,200,148)
2001						(21,942,175)
2002						(19,902,135)
2003						(15,562,165)
2004						(23,216,868)
TOTALS	2,000	$ 50	50	$ 100,000	$ 37,700,084	

CHARTER AND BY-LAWS

The Plan's original Charter dated September 14, 1990, was filed and recorded with the Tennessee Secretary of State. The original Charter was not stamped as being approved by the TDCI. However, the Plan's original Charter was filed with TDCI during the "Qualifying Examination" and subsequent approval by granting the Plan's its original Certificate of Authority. The original Charter indicated a perpetual existence and established a for-profit corporation. The initial registered agent in Tennessee was C T

Corporation System located at 530 Gay Street, Knoxville, Tennessee 37902. Subsequent amendments to the Charter are presented as follows:

Effective Date of Amendment	Purpose of Amendment
May 3, 1991	To change the par value of the Plan's common stock from one cent ($0.01) per share to fifty dollars ($50) per share.
May 1, 1996	To change the name of the Plan from Complete Health of Tennessee, Inc. to United HealthCare of Tennessee, Inc.
December 4, 1996	To change the location of the Plan's principal office from 2160 Highland Avenue, Birmingham, Alabama 35205, to 3401 West End Avenue, Suite 690, Nashville, Tennessee 37203.
October 23, 2000	To change the location of the Plan's principal office from 3401 West End Avenue, Nashville, Tennessee 37203 to 10 Cadillac Drive, Suite 200, Brentwood, Tennessee 37027.

Neither the December 1996 nor the October 2000 amendments were filed for approval with the TDCI prior to filing with the Secretary of State and the Plan's resident county. During the period of examination, the Plan adopted a "Policy and Procedure" whereby the Plan will provide at least a 30 day notification to TDCI prior to any modification of the Plan's Charter.

The Plan's Bylaws as adopted May 1, 1996, and approved by the Board of Directors on April 24, 1996, were in effect during this period of examination. The Bylaws are such as generally found in corporations of this type. The Bylaws provide for an annual shareholder meeting at which the Board of Directors is elected. Officers are elected by the Board of Directors annually at the first Board of Directors' meeting. The Bylaws may be amended or repealed by a majority of the Board of Directors, unless otherwise provided by the articles of incorporation or by the laws of the state of incorporation.

MANAGEMENT AND CONTROL

Holding Company System:

The Plan is a member of a health maintenance organization holding company system as defined by Tenn. Code Ann. § 56-11-201(5). The Plan became a wholly owned subsidiary of UHCI, a Delaware holding company, on June 30, 2000. UHCI is a wholly owned subsidiary of UHCS, an HMO management corporation which provides services to the Plan under the terms of a management agreement. UHCS is wholly owned by UHG, the ultimate parent of the holding company system. Prior to March 6, 2000, UHG was known as United HealthCare Corporation, Inc. It will be referred to as UHG from this point forward in this report. An organizational chart is attached herein as Addendum A.

Shareholders:

The Plan is wholly owned by UHCI, which is the sole shareholder. The Plan's Charter is silent as the duties of the shareholders; however, the Bylaws as amended May 1, 1996, state the following:

> *Annual meetings of the shareholders, commencing with the year 1991, shall be held on the 4th Thursday in March if not a legal holiday or at such other date and time as shall be designated from time to time by the board of directors, . . . at which they shall elect by plurality vote a board of directors, and transact such other business as may be properly brought before the meeting.*

Special meetings "may be called by the president, the board of directors, or the holders of at least ten (10%) percent of all the votes entitled to be cast . . .".

Each outstanding share, regardless of class, is entitled to one (1) vote and a "majority of votes entitled to be cast on a matter by the voting group constitutes a quorum..." Shareholders may vote in person or by proxy executed in writing. Actions of the shareholders may be taken by written consent in lieu of a meeting if the consent is "signed by all of the shareholders entitled to vote".

The shareholders held no meetings during the examination period. All actions were by written consents in lieu of meetings. The written consent in lieu of the 2001 annual meeting was dated March 3, 2001. As permitted by the Bylaws the sole shareholder presented a timely notice to the Board of Directors of UHCS changing the date of the annual shareholder meeting from the fourth Thursday in March. The written consent in

lieu of the 2002 annual meeting was executed on March 28, 2002, in accordance with the Bylaws. The written consent in lieu of the 2003 annual meeting was dated March 27, 2003 in accordance with the Bylaws. The written consent in lieu of the 2004 annual meeting was dated March 25, 2004 in accordance with the Bylaws.

Board of Directors:

The Plan's Bylaws state that the "business affairs of the corporation shall be managed by its board of directors which may exercise all such powers of the corporation" as allowed by law, the Charter and Bylaws. The number of Board of Directors "shall not be less than two (2) nor more than eleven (11)" and "shall be elected at the annual meeting of the shareholders, and each director elected shall hold office until his successor is elected and (since) qualified." Vacancies on the Board of Directors "may only be filled by the shareholders." A quorum is defined as "a majority of the number of directors . . . unless a greater number is required by law or by the articles of incorporation."

The following persons were duly elected by the shareholders and were serving as members of the Board of Directors as of December 31, 2004:

Director	Home City and State	Principal Affiliation
David Scott Wichmann	Burnsville, Minnesota	Director and Executive Vice President of the Plan; CEO of UHCI.
Robert John Sheehy	Edina, Minnesota	Director of the Plan; Vice President of UHCS; Director of UHCI
Charles Brian Shipp	Brentwood,Tennessee	Director and President of the Plan; Senior Vice President of UHG

The dates of the annual meetings of the Board of Directors are fixed by the shareholders at their annual meetings. For the period under examination, annual Board of Directors meetings were held on the same day as the written consent in lieu of shareholders' meeting dates. "Regular meetings of the board of directors may be held upon such notice, or without notice, and at such time and at such place as shall from time to time be determined by the board." Action may be taken by the Board of Directors without a meeting if "evidenced by one or more written consents describing the action taken, signed by each director, and included in the minutes or filed with the corporate

records reflecting the action taken." During the examination period, all actions of the Board of Directors were by written consent.

Officers:

The Bylaws provide that after each annual meeting of the shareholders, the Board of Directors "shall choose a president, one or more vice-presidents, a secretary and a treasurer, none of whom need be a member of the board." The Board of Directors may also appoint "such other officers and agents as it shall deem necessary..." The Bylaws also state that "the same individual may simultaneously hold more than one office." Vacancies "shall be filled by the board of directors or by an officer authorized by the board of directors."

At December 31, 2004, the following persons had been duly elected to and were serving in the positions indicated:

President and Chief Executive Officer	Charles B. Shipp
Vice President and Assistant Treasurer	David S. Wichmann
Vice President of Finance and Assistant Treasurer	George L. Mikan III
Treasurer	Robert W. Oberrender
Secretary	Michael J. McDonnell
Assistant Secretary	David J. Lubben
Assistant Secretary	Timothy G. Caron
Assistant Secretary	Mary L. Stanislav
Vice President of Tax Services	John W. Kelly

Investments:

Tenn. Code Ann. § 56-3-408(b)(1) states that "No investment or loan except premium finance loans, shall be made by any such insurance company, unless the same shall first have been authorized by the board of directors or by a committee appointed by such board and charged with the duty of supervising such investment or loan."

The Board of Directors reviews and ratifies the investment transactions of the Plan on a quarterly basis.

In December 2004, the Plan's Board of Directors adopted the UHG's Investment Policy dated November 2004 and acknowledged that any investment policy must be in compliance with Tennessee statues and regulations.

In December 2004 the Board of Directors adopted the UHG's "Intermediate Portfolio Guidelines as of November 2004" which will "to be used in conjunction with the UnitedHealth Group Incorporated Investment Policy" and is "intended to provide additional restrictions and/or information for managing individual portfolios."

Investment Management Agreement: Effective January 6, 1998, UHCS, acting on behalf of the Plan, entered into an Investment Management Agreement with Wellington Management Company, LLP. Under this agreement Wellington Management Company, LLP. "shall be responsible for the investment and reinvestment of those assets designated" by the Plan. Securities are actually held by a Custodian duly appointed by the Plan. Wellington Management Company, LLP. "is authorized to give instructions to the Custodian with respect to all investment decisions". Wellington Management Company, LLP. is compensated quarterly in arrears according to the terms presented on Exhibit C of this agreement . This compensation formula remains unchanged since the inception of this agreement. The Plan and other entities listed in the Investment Management Agreement "are understood to be third-party beneficiaries of this Agreement and shall have full rights to enforce it and to receive its benefits."

Custodian Agreement: The approval of the current and prior custodian agreements falls within the scope of the Amended and Restated Management Agreement by and between UHS and the Plan effective as of December 31, 1999. See the "Management Agreement" subsection below for further details.

On August 4, 1998, the Plan's Board of Directors granted approval for the Treasurer, Assistant Treasurer, Secretary and Assistant Secretary to designate, via written certificate, UHG representatives that shall "establish accounts and to transact any and all business with such banks as they deem necessary and appropriate, provided that a copy of such certificate be placed with the minute book" of the Plan.

Effective April 30, 2002, UHG and each of its affiliates, including the Plan as noted in Exhibit B of the hereto described agreement entered into an Amended and Restated Custodian Agreement with State Street Bank and Trust Company. This Amended and Restated Custodian Agreement replaced the original Custodian Agreement effective April 24, 1997, by and between UHG and State Street Bank and Trust Company. UHG appointed State Street Bank and Trust Company as custodian for the safekeeping of

securities. According to the Custodian Agreement, "State Street shall hold all securities and other property received in an account for the Participants entitled 'United HealthCare Liquidity Pool'". The Plan is explicitly named as a participant in the Custodian Agreement. The Custodian Agreement contains language for safeguards and controls as required by the NAIC. However, the agreement does not meet two (2) specific requirements set forth in Tenn. Comp. R. & Regs., 0780-1-46.04. This is further discussed in this report in the sections marked "Recommendations" and "Subsequent Events".

On April 6, 2004, the Plan's Treasurer and Assistant Secretary authorized three (3) specific individuals to give investment instructions to State Street Bank and Trust Company on behalf of UHG and its subsidiaries and affiliates, which includes the Plan. This approval was granted by the Board of Directors of the Plan.

Pecuniary Interest:

Compliance with Tenn. Code Ann. § 56-3-103 was reviewed and it was determined that no Board of Director or officer of the Plan had a pecuniary interest in the investment or disposition of Plan's funds.

Conflicts of Interests:

The Plan has no employees. Personnel and services are provided by the Plan's affiliate, UHCS, in accordance with the Management Agreement. This is further discussed in this report in the section marked "Management Agreement".

Board of Directors, officers and key personnel are required annually to complete a Conflicts of Interest and Outside Directorships Disclosure Form. This form is used for all entities within the UHG holding company system. It appears that persons required to complete the certificate sign a separate form for each entity within the holding company system. The Conflicts of Interest and Outside Directorships Disclosure Forms are submitted and reviewed by UHG legal services. The Plan's secretary submits an annual Conflict of Interest Report to the Board of Directors. The 2004 Conflict of Interest Report noted that:

> *The potential for conflicts was reported by several individuals who are also officers and/or directors of other entities within the UnitedHealth Group of companies. In connection with those positions, from time to time, matters may arise as to which a conflict may exist with respect to the operations of this Corporation [the Plan]. The potential conflicts reported were reviewed by management and not deemed to be material.*

Personnel may "not serve on the board of directors of any company that competes with UnitedHealth Group or has a significant commercial relationship with UnitedHealth Group," and must get approval from their supervisor before becoming a board member of any for-profit organization. Also, personnel are encouraged to "raise questions about possible conflicts of interest and disclose these kinds of situations" to their "supervisor or the Compliance Line as they arise." In addition, the Plan has an integrity officer who is assigned by UHG and administers the comprehensive Integrity and Compliance Program.

The examiners reviewed the Conflicts of Interest and Outside Directorships Disclosure Form signed by the Plan's Board of Directors and officers for the period under examination. No exceptions were noted that were deemed to be a violation of Tenn. Code Ann. § 56-3-103.

Committees:

The Plan's Bylaws state that the Board of Directors "may create one or more committees and appoint members of the board to serve on them." The minutes of the Board of Directors do not reflect the creation of any new committees during the period under examination. However, during the period of examination the Plan created and abolished various committees. In 2003, the Plan abolished the Service Improvement and the Integrity and Compliance committees and implemented the Integrated Activities Committee,, National Pharmacy and Therapeutics Committee and the Peer Review Committee. The Plan's committees have their membership dictated by job title. These committees are responsible for both the Tennessee and Arkansas operations. The Plan's primary committees are described below:

Executive Oversight Committee: The purpose of the Executive Oversight Committee "is to establish organizational accountability, responsibility, authority in health plan business operations, quality improvement, the evaluation and improvement of clinical care and service to customers. It ensures organizational compliance to corporate policies and federal, state, and local regulations."

The Plan's description of the Executive Oversight Committee states that it meets at least quarterly and reports to the Board of Directors. No formal report from this committee is documented in the Board of Directors minutes. The Plan's Chief Executive Officer and

the chairperson of the Executive Oversight Committee present a quarterly report to the Board of Directors that includes updates on other committees.

This committee also appoints and provides direction to those committees that report to it.

Quality Improvement Committee: The Quality Improvement Committee's purpose is "to provide program direction and continuous oversight of quality improvement activities in the areas of clinical care, service, patient safety, administrative processes, compliance and network credentialing and re-credentialing" The Quality Improvement Committee also oversees a number or other committees. The committee is chaired by the Market Quality Consultant and reports to the Executive Oversight Committee. A Quality Improvement Committee report is presented to the Board of Directors on a quarterly basis.

Integrated Activities Committee: The Integrated Activities Committee is responsible "for oversight of delegated and matrix partner activities". For example, "if any services normally provided by the healthplan are formally delegated to a contracted organization, the contracted entity is accountable to the Plan to demonstrate acceptable policies, quality improvement processes and evidence of ongoing implementation." The committee is chaired by the Senior Medical Director and reports to the Quality Improvement Committee. The Integrated Activities Committee report is presented to the Quality Improvement Committee on a quarterly basis.

Medical Standards: The Medical Standards Committee is responsible for reviewing, monitoring and advising the Plan about "clinical quality improvement activities". This committee also serves as a liaison between the Plan and its provider network. It also provides a forum for providers to participate in decisions that impact the quality of medical care and services rendered by the Plan. The committee reports to the Quality Improvement Committee and is chaired by the Plan's Medical Director.

National Pharmacy and Therapeutics Committee: The National Pharmacy and Therapeutics Committee "is responsible for providing the clinical oversight for the development and maintenance of the Preferred Drug List and Clinical Pharmacotherapy

policies. The National Pharmacy and Therapeutics Committee promotes the use of appropriate drug therapies based on clinical evidence and meets approximately six (6) times per year. Any recommendations made by the National Pharmacy and Therapeutics Committee are reviewed by the local health plan Medical Standards Committee as appropriate.

Network Oversight Committee: The Network Oversight Committee reviews and monitors composition and characteristics of the contracted provider network to ensure that network standards are maintained. These standards are primarily associated with accessibility and availability of qualified providers to meet the needs of the Plan's members. This committee reports directly to the Quality Improvement Committee and meets at least six (6) times per year.

Credentialing Committee: The Credentialing Committee performs the provider credentialing and re-credentialing functions of the Plan and reviews individual cases regarding potential issues of quality of care. This committee reports to the Network Oversight Committee.

Peer Review Committee: This Peer Review Committee was formed in 2003 to assure "that the clinical care provided by contracted physicians and facilities are conducted in a manner consistent with Evidence-Based Medicine protocols and in concert with community standards of care". The Peer Review Committee reports directly to the Network Oversight Committee and meets on an as needed basis.

The Plan does not have an Audit Committee. However UHG maintains an Audit Committee that is comprised of three (3) or more directors, appointed by UHG's Board of Directors at their annual organizational meeting and serves continuously until their resignation or replacement. The primary purpose of UHG's Audit Committee is as follows:

> *assist the Board's oversight responsibilities relating to the integrity of UHG's financial statements (which also includes the Plan's financial statements), UHG's compliance with legal and regulatory requirements (this responsibility is shared UHG's 'Compliance and Government and Affairs Committee), the performance, qualifications and independence of UHG's independent outside auditor, the performance of UHG's General Auditor and outsourced internal audit function, and*

to prepare the report required by the Securities and Exchange Commission to be included in UHG's annual proxy statement.

AGREEMENTS WITH PARENT, SUBSIDIARIES AND AFFILIATES

Management Agreement: On December 31, 1999, the Plan entered into an Amended and Restated Management Agreement with UHCS, whereby:

(a) Plan shall engage in the business of arranging for the provision of health care coverage to its enrollees, and
(b) UHS shall provide to Plan certain administrative, financial and managerial services necessary for its day-to-day operations subject to the directions of the Plan's Board of Directors.

These services include, but are not limited to, maintaining the Plan's books and records; providing human resources; assisting with the Plan's regulatory compliance, including the preparation of financial statements; retaining office space, furniture and equipment; providing all necessary services to providers and enrollees, including claims processing; maintaining accounting, billing and collection systems; and investing Plan assets.

Other entities in the holding company system are paid by the Plan through UHCS according to a clause in the Management Agreement which states that UHCS shall "establish a process by which, on a regular basis, the Plan may make payments to and receive payments from, affiliated entities of UHS with whom either Plan or UHS may have contractual relationships by which products or services are performed on behalf of or for the benefit of, the Plan."

The Management Agreement provides for the Plan to pay UHCS a monthly management fee which is "calculated as percentage of Plan's gross revenues for that month." The fee is to be paid "on or before the 10th calendar day of each month." Management fees under the Management Agreement totaled approximately $9,755,000 in 2004 and $16,812,000 in 2003. These fees were allocated between claims adjustment and general and administrative expenses on the "Statement of Revenues and Expenses" in the annual statements. The terms of the Management Agreement, including the management fee, have not changed since its December 31, 1999, inception date. The Management Agreement was filed with and approved by the TDCI on January 13, 2000, in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D).

Pharmacy Benefit Service Agreement: Effective January 1, 2004, UHCS entered into a Pharmacy Benefit Service Agreement with Medco Health Solutions, Inc. ("Medco"). Under the Pharmacy Benefit Service Agreement, Medco provides pharmacy benefit administration services to the Plan including claims and rebate processing, eligibility and benefits administration, customer service for members, retail and home delivery pharmacy network management and implementation and operational support for pharmacy programs.

No later than 12:00 PM Central Standard Time on the first Tuesday following the end of each two-week claims cycle, Medco electronically supplies UHCS with the data files for processed paid claims for prescription drug services. UHCS remits payment to Medco via Automated Clearing House or wire transfer no later than the first Monday following submission of claim files invoiced to UHCS. If any claims are not successfully processed due to error by the payment due date, UHCS will remit payment within one (1) business day after the claims have been successfully processed through UHCS's system.

The Plan pays Medco an administrative fee for Covered Prescription Drug Services Every fourth Wednesday, no later than 8:00 AM Central Standard Time, Medco shall provide UHCS with a report of administrative fees earned and the corresponding paper invoices for covered claims processed. UHCS shall pay Medco for administrative fees invoiced no later than the first Monday after UHCS receives the administrative fee files. The Plan also pays for services not otherwise described in the Pharmacy Benefit Service Agreement, such as physician profiling, identification cards, prescription benefit records and explanation of benefit forms. In 2004 and 2003, the Plan paid Medco approximately $37,000 and $79,000, respectively. These expenses were included in claims adjustment expenses on the "Statement of Revenues and Expenses" in the annual statements.

The Pharmacy Benefit Service Agreement also provides for Medco to remit to UHCS on a quarterly basis estimated rebates earned from pharmaceutical manufacturers that directly relate to covered prescription drug services. Actual rebates paid are reconciled twice with estimated rebates earned. The first reconciliation is performed 45 days after the end of each calendar quarter and the second reconciliation is performed 450 days after the end of each calendar quarter.

The Pharmacy Benefit Service Agreement was not required to be filed for approval with TDCI.

Behavioral Services Agreements: At the request of the Actuarial Division of TDCI, the Plan entered into two (2) separate agreements with United Behavioral Health, Inc. :

1. The Mental Health and Substance Abuse Services Agreement for HMO Business with United Behavioral Health, Inc. provides HMO covered members with emergency room, inpatient, outpatient and detoxification services which include psychological testing, diagnostic procedures, treatment programs and inpatient medications. The services provided also include utilization management services "to facilitate the continuity, cost effectiveness and appropriateness of care; including clinical triage, referral, prior authorization, concurrent review and discharge planning".
2. The Mental Health and Substance Abuse Services Agreement for Non-HMO Business provide individuals covered by all Non-HMO benefit plans with the same services as the HMO Business.

The above two (2) agreements each containing two (2) amendments for rate increases were approved by TDCI and effective as of May 16, 2003, in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c). However, the Plan recognized an effective date of January 1, 2001. Fees related to these two (2) agreements were approximately $572,000 in 2004 and $1,125,000 in 2003 and were included in hospital / medical benefits on the "Statement of Revenues and Expenses" in the annual statements.

The Plan had previously entered into a single agreement for provision of services with United Behavioral Health, Inc. United Behavioral Health, Inc. provided mental health and substance abuse services to the Plan's HMO and non-HMO members. The above stated agreement was amended seven (7) times after its original effective date of January 1, 1995. All amendments were for revision of rates for applicable services.

Transplant Services Agreement: Effective December 2, 1997, the Plan entered into a Transplant Services Agreement with UHCS on behalf of United Resource Networks. Under the Agreement, UHCS arranged for the Plan to obtain access to certain participating providers for the provision of transplant services. The Plan may also retain UHCS to negotiate discounts "for Transplant Services that are not included in the Participation Agreements or not rendered by Participating Providers." The Plan will pay

UHCS a monthly fee due the first day of each month for these services. Fees related to this agreement were approximately $64,000 in 2004 and $81,000 in 2003 and were included in hospital / medical benefits on the "Statement of Revenues and Expenses" in the annual statements. This original Transplant Services Agreement was approved by TDCI on August 4, 1999, with a December 2, 1997, effective date. TDCI approved this Agreement in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c).

The Transplant Services Agreement was amended five (5) times . Each amendment was approved by the TDCI in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c). The amendments are summarized as follows:

1) Amendment to include Medicare+Choice language pursuant to the United States "Balanced Budget Act of 1997" at the direction of the Medicare and Federal Health Care Financing Administration with a retroactive effective date of January 1, 1999.
2) Amendment to increase rates for the calendar years 2001 and 2002 and an additional rate increase for calendar year 2003 effective January 1, 2001.
3) Amendment deletes Section 2.4 and replaced Section 2.4 with UHCS "will not engage in any conduct having the purpose or which has the effect of unlawfully discriminating or differentiating in the rendering of Transplant Services to Members"
4) Amendment to Section 4.8 adds an attached Transplant Access Program Appendix, Congenital Heart Disease Services Appendix, Cancer Resource Services Appendix and an Extra Contractual Services Appendix
5) Amendment increases the base Transplant Utilization Rate; increases the Congenital Heart Disease Services Appendix rate and decreases the Cancer Resource Services Appendix rate.

Optum® Services Agreement: This agreement is between Optum and UHCI and is "on behalf of plans that are affiliated with United HealthCare," The *Optum® Services Agreement* was effective November 1, 1999, was last amended January 1, 2004 Four (4) Restated Participating Plan Addendums and four (4) Amendments to this agreement were added from 2001 through 2004. All four (4) addendums and amendments were submitted

via Form D filings and approved by TDCI in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c). The fourth and last addendum and amendment executed during the period of examination was approved by TDCI on May 17, 2004.

Under two (2) addendums and four (4) Restated Participating Plan Addendums, Optum® provides "Care24 Services (originally effective January 1, 2000)" and "Nurseline Services (originally effective January 1, 2000)". Collectively, these service addendums provide toll-free telephone counseling sessions available 24 hours a day and 365 days a year for marital and family relations, dependent care, alcohol or chemical dependency, financial and related legal issues, illnesses, work related problems, general health information, identification of specific health-related concerns and provision of educational information regarding these concerns. Care24 services are "provided by master's degree level Optum® Staff counselors and/or by Optum® Staff nurses, as Optum® determines appropriate." Plan members are limited to three (3) sessions per problem per year. The current rate structure for Care24 services includes provisions for performance standard failure reimbursements. There is a separate rate structure for Nurseline services.

Under a third addendum, Optum® also provides health and well being information services. These services are accessed via an internet website and include a variety of printed material and interactive tools. Currently the fee for the health and well being information services is included in the Care24 services fee.

Fees related to all services provided by Optum®, including the Health Pregnancy Services Agreement, were approximately $302,000 in 2004 and $541,000 in 2003 and were included in hospital and medical benefits on the "Statement of Revenues and Expenses" in the annual statements.

Optum® Healthy Pregnancy Services Agreement: This agreement between Optum® and UHCS was effective January 1, 1999. This agreement is separate and apart from the above referenced *Optum® Services Agreement* effective November 1, 1999. This agreement is for healthy pregnancy services and provides for "periodic telephonic screening of the pregnant Covered Person [member] by a registered nurse." The nurse assesses the member's needs and provides educational material.

The Plan's agreement and the additional four (4) amendments all bear the September 30, 2003, approval date by the TDCI in accordance with Tenn. Code Ann. §

56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c). Each amendment is summarized as follows:

1 Service Delivery hour changes in addition to "Enhanced Needs-Medical" Services provided effective January 1, 1999.

2 Utah participating plan addendum June 2, 1999.

3 Health Pregnancy Service Fee Increase that is dependent upon the number of cases and whether or not the member has Medicaid coverage effective January 1, 2002.

4 Revised "Participating Plan Attachment" effective June 1, 2002.

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   a) Cancellation of Medicaid Enrollees services,
   b) Payment invoice to be completed upon a "Covered Person's" first screening session. The rate does not include the cost of prenatal packets, additional educational materials, marketing materials or the costs of mailing to "Covered Persons".
   c) Revised "Participating Plan Attachment" effective January 1, 2003.

Chiropractic Services Agreement: Effective January 1, 2003, the Plan entered into a Chiropractic Services Agreement with American Chiropractic Network, Inc, UHCS and United Health Networks, Inc. via a Participating Plan Addendum to the Master Services Agreement. The Master Services Agreement contained a "Chiropractic Services Addendum" and a "Complementary & Alternative Medicine Services Addendum". Under the terms of the agreement, American Chiropractic Network, Inc provides the Plan with network management and administration of chiropractic and complementary and alternative medicine services. Simultaneous to the execution of the agreement the Plan entered into a first amendment to reflect the name change from American Chiropractic Network, Inc. to ACN Group, Inc. (ACNG) and add the definition "Clinical Support Program" to better reflect the nature of the service ACNG provides the Plan. This "Master Services" agreement, first amendment and addendum were approved by the TDCI in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c) on March 19, 2003.

The Plan, ACNG, UHCS and United Health Networks, Inc. entered into a second amendment to the "Master Services" agreement to replace the "Clinical Support Program" with the "Clinical Support Program Plus" which now includes utilization review services.

Also, this second amendment completely deletes the "Chiropractic Services Addendum" and replaces it with a "Network Management" and "CSP Plus" addendums. This second amendment was approved by the TDCI in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c) on January 30, 2004.

Fees related to this agreement were approximately $108,000 in 2004 and $171,000 in 2003 and were included in hospital / medical benefits on the "Statement of Revenues and Expenses" in the annual statements.

Coordinated Vision Care Services Agreement: Effective November 1, 2001, the Plan entered into a "Participating Plan Addendum" to a "Coordinated Vision Care Services Agreement" with UHCS and Coordinated Vision Care, Inc., a Delaware Corporation. Under the agreement Coordinated Vision Care, Inc. is responsible for developing, contracting and managing a network of participating providers to provide vision care services and products (frames and lenses) to the Plan's members. Prior to the Plan becoming a party to this agreement two (2) amendments were instituted. The first amendment, effective March 1, 2000, added United Health Networks, Inc. as a party to the Agreement. The second amendment, effective November 1, 2000, revised the agreement to replace all references to Coordinated Vision Care, Inc.: with the defined term "Payor". Fees related to this agreement were approximately $25,000 in 2004 and $51,000 in 2003 and were included in hospital / medical benefits on the "Statement of Revenues and Expenses" in the annual statements. The *Coordinated Vision Care Services* Agreement and the first and second amendments were approved by the TDCI in accordance with Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c) on August 6, 2001.

Premium Allocation Agreement: As discussed above, the Plan is party to a management agreement with UHCS. Another affiliate, United HealthCare Insurance Company ("UHI") provides health insurance coverage which is marketed and issued in conjunction with products marketed by the Plan. Therefore, effective January 1, 1998, UHI and UHCS entered into a Premium Allocation Agreement whereby UHI is entitled to receive consideration for these products which shall be "(i) fair and reasonable; (ii) determined according to actuarial review conducted at least annually; (iii) allocated in conformity with customary insurance accounting practices consistently applied." The Plan

is bound to this agreement by addendum. This agreement was never filed for approval with TDCI as required by Tenn. Code Ann. § 56-11-206(a)(2)(D) and Tenn. Code Ann. § 56-32-203(c). The Plan stated in a letter dated December 30, 2004, addressed to the TDCI "The Allocation Agreement will not be filed for approval since it has not been in use since December 31, 2000".

Tax Sharing Agreement: A Tax Sharing Agreement by and among UHG and its subsidiaries was effective January 1, 1990, and last amended October 1, 1996. The Plan became a party to the agreement on June 1, 1994. The agreement provides that:

> *A Consolidated Tax Return shall be prepared and filed by the UHC Group [UHG] for the taxable year ended December 31, 1990, and for each subsequent taxable year in respect of which the Agreement is in effect . . .*
> *Each member shall pay [UHG] . . . an amount equal to the full separate federal, state and local (if any) income tax liability attributable to the net taxable income of such Member that would have been paid if such Member had filed separate federal, state and local income tax returns.*
> *[UHG] shall have the responsibility and authority to act as the agent for each Member in making tax payments due the IRS, state and local government authorities as well as collecting refunds due from such tax authorities.*
> *[UHG] shall, within sixty (60) days after filing the return, refund to the applicable Member(s) any overpayment."*

The agreement provides for other subsidiaries to be joined to the agreement as necessary.

Subordinated Revolving Credit Agreement: By Addendum effected December 20, 1999, the Plan became party to the Subordinated Revolving Credit Agreement by and between UHG and other entities in the holding company system. The agreement is designed to meet the short-term cash needs of the Plan and its affiliates.

Under the agreement, UHG agrees to "lend and re-lend to Borrower such amounts as Borrower may request, not to exceed the aggregate principal amount," which is $5,000,000. The agreement was renewed effective December 1, 2004, and will be automatically renewed annually unless "either party gives written notice to the other party at least 60 days prior to the termination date of its intent to terminate" the agreement. Interest on the outstanding balance of each loan is calculated as the London Interbank Offered Rate plus 50 basis points.

The Plan had no outstanding debt under this agreement at December 31, 2004, or December 31, 2003, but did report borrowed money of $700,000 at June 30, 2001.

Transition and Joint Marketing Agreement: On March 1, 2001, the Plan's Board of Directors approved the implementation of a Transition and Joint Marketing Agreement by and between UHCS, Vanderbilt Health Services, Inc., Health 1-2-3 and Vanderbilt University through Vanderbilt University Medical Center. This agreement caused the transition of certain enrollees from Health 1-2-3, to the Plan. Health 1-2-3 was an H.M.O. licensed only in Tennessee. This agreement was approved by TDCI in accordance with Tenn. Code Ann. § 56-32-203(c) on March 12, 2001.

CORPORATE RECORDS

The Plan's original Certificate of Authority was issued September 13, 1991, and was replaced by a certificate dated May 9, 1996, when the Plan changed its name. The current Certificate of Authority was issued January 1, 2001, and is effective until suspended or revoked.

The minutes of the annual meetings of the Plan's sole shareholder (UHCS) were provided to the examiners. The shareholder's primary function is to elect directors to the Board of Directors annually.

The meeting minutes of the Plan's Board of Directors were provided to the examiners for the period under examination. The minutes are well-written, complete as to necessary detail and appear to properly reflect the actions of the Plan's Board of Directors. Attachments and exhibits provided to the Board of Directors are maintained with the minutes.

The Plan's corporate records are maintained primarily at the offices of UHCS, at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343.

STATUTORY DEPOSITS

In compliance with Tenn. Code Ann. § 56-32-212(b), the Plan was maintaining the following deposits for the benefit of all enrollees at December 31, 2004:

Jurisdiction	Description	Par Value	Statement Value	Market Value
Tennessee	U.S. Treasury Note, 5.75%, due 11/15/05, CUSIP #9128276N7	$350,000	$361,084	$358,971
Tennessee	U.S. Treasury Note, 2.375%, due 8/15/06, CUSIP #912828BF6	$1,800,000	$1,791,821	$1,782,918
Totals		$2,150,000	$2,152,905	$2,141,889

The above deposits were verified with the custodian for TDCI. It was noted that the Plan's records at December 31, 2004, reflected an additional deposit of $40,035 (par value) in the form of a FHLMC. This bond was released in May 2004, by the TDCI due to the accumulated deposit total exceeding the amount required by Tenn. Code Ann. § 56-32-212(b)(1) and (3). This transaction was in accordance with Tenn. Code Ann. § 56-32-212(b)(4). The Plan's premium revenue for 2004 indicates a statutory deposit level of $1,512,482 in accordance with Tenn. Code Ann. § 56-32-212(b)(2) and (3). The Plan is in compliance with the statutory deposit requirements. This is further discussed in this report in the sections marked "Status of Prior Examination Findings" and "Comments" .

FIDELITY BOND AND OTHER INSURANCE

The Plan and UHCS are included as named insureds by endorsement on the coverage afforded UHG. UHCS employs individuals that perform business functions on behalf of the Plan. The crime and fidelity coverage are underwritten by National Union Fire Insurance Company of Pittsburgh, Pennsylvania. The fidelity bond has an occurrence/aggregate limit of $10,000,000, with a $25,000,000 retention. The minimum range recommended by the NAIC for a Plan of this size is $600,000 to $700,000. Therefore, the Plan had fidelity coverage which exceeded the minimum fidelity coverage recommended by a comfortable margin.

The Plan's coverage is summarized as follows:

Type or Class of Coverage	Limits, Retentions and Deductibles
Fidelity Bond (E & O)	$10,000,000 per occurrence/aggregate

	with $25,000,000 retention
Blanket Crime Policy	$25,000,000 with $500,000 retention (includes computer fraud and funds transfer fraud)
Managed Care Professional Liability	$30,000,000 per claim/aggregate with a self-insured retention of $3,000,000 per claim/$30,000,000 aggregate
Commercial General Liability	$3,000,000 General Aggregate Limit, $1,000,000 Products / Completed Operations Aggregate Limit, $1,000,000 Each Occurrence Limit, $1,000,000 Advertising Injury and Personal Injury Aggregate Limit, $1,000,000 Damage to Premises Rented to You Limit, $250,000 Bodily Injury and Property Damage Deductible Per Claim, $250,000 Advertising Injury and Personal Injury Deductible Per Claim, $1,000,000 Employee Benefits Errors and Omissions Aggregate Limit, $1,000,000 Employee Benefits Errors Limit Each Claim, $100,000 Deductible Each Claim
Business Auto Liability	$1,000,000 Limit Each Accident (no retention, except $1,000 for physical damage),$1,000,000 Uninsured Motorists and $5,000 Auto Medical Payments
Workers' Compensation	Statutory
Commercial Umbrella	$25,000,000 Each Occurrence; $25,000,000 General Aggregate; $25,000,000 Products/Completed Operations Aggregate; $10,000 self-insured retention

Employers Liability	$1,000,000 by accident / each employee
Commercial Property (Blanket)	$25,000,000 for Contingent Time Element, Data, Programs or Software, Service Interruption; $10,000,000 Accounts Receivables, Commissions, Profits, Errors and Omissions, Valuable Papers; $500,000,000 for Certified Acts of Terrorism; $250,000,000 Terrorism (Non-certified); $250,000,000 Earth Movement.

The Plan's General Liability and Business Auto Liability coverage was provided by Federal Insurance Company. The Plan's Commercial Umbrella Excess Liability coverage was underwritten by St. Paul Fire and Marine Insurance Company. The Plan's Commercial Property (Blanket) policy was underwritten by Factory Mutual Insurance Company. The Plan's Workers' Compensation policy was carried by United States Fidelity and Guaranty Insurance Company. The Plan's Employers Liability coverage was issued by Fidelity & Guaranty Insurance Company.

The Plan's Managed Care Professional Liability coverage was underwritten by H & W Indemnity, Ltd., which is domiciled in the Cayman Islands. H & W Indemnity, Ltd. was not a licensed insurance carrier or an approved alien or foreign surplus lines carrier in the State of Tennessee as of the date of this examination. The TDCI encourages domestic companies to obtain insurance coverage from companies licensed or approved to do business in the State of Tennessee, unless it is proven to be unavailable. This is further discussed in this report in the "Comments" section.

All coverage afforded UHG were issued by insurance companies authorized to transact business in the State of Tennessee, except for the Managed Care Professional Liability policy.

EXCESS LOSS REINSURANCE

Effective December 31, 2004, the Plan and TDCI mutually agreed that the Plan should cease from using Stop Loss Agreement Number RSA-103 issued by UHI. The Plan removed the effect of this agreement from the 2001 through 2004 annual statement(s) using "one time" accounting entries in the 2004 annual statement. Prior to

December 31, 2004, the Plan was afforded the following excess loss coverage as provided by UHI:

Type of Contract:	Stop Loss Agreement Number. RSA-103
Business Insured:	Eligible Inpatient Services which "shall be those acute care services rendered to registered bed patients which are provided under the [Plan's] Membership Service Agreements." Acute care services "shall mean short-term medical services that are required to be provided in a licensed acute care hospital."
Term:	January 1, 2000, to continue in full force until terminated. Either party may terminate "by giving the other party written notice of such intention to terminate at least ninety (90) days prior to the anniversary of the effective date" of the agreement.
Limits and Retentions:	90% in excess of $150,000 Plan retention per each member per contract year. The "maximum stop loss coverage payable under this Stop loss agreement for Eligible Inpatient Services shall be $1,000,000 per member." This was changed to $2,000,000 by Amendment # 1 effective January 1, 2001.
Premium:	A flat fee for each eligible member per month due on the 10th day of the month for which coverage is to be provided. Premiums are based on an estimate of the number of Plan members covered and eligible to receive inpatient services for the month plus an adjustment for the previous month(s) actual versus estimated number of members.
Endorsement No. 1:	In the event of the Plan's insolvency, UHI will: 1) Continue Plan benefits for members receiving non-custodial care while confined in an inpatient facility on the date of the insolvency until their discharge; 2) Continue Plan benefits until the end of the contract period for which premium was paid to the Plan before the date of insolvency, not to extend beyond 30 days.

3) Provide each member and covered dependents the right to convert within 30 days of the date of insolvency, without evidence of insurability, to coverage then being offered by UHI to other insureds eligible for conversion under its group policies with the same benefits and at the same rates offered to such other insureds. This endorsement was effective January 1, 2000.

Endorsement No. 2: In the event that a non-Medicare Plan member relocates outside of the Plan's service area, UHI shall offer such member, without evidence of insurability, a conversion policy with substantially similar benefits and at such rates as are then being offered through UHI to others eligible for conversion. Premium for this coverage is a flat fee for each member per month. This endorsement was effective January 1, 2000.

Amendment No. 1: Replaced Article II, Paragraph A language and added a new "deductible amount for stop loss coverage shall be specified on Schedule A hereto of the Loss for each Member during each Contract Year. Once the deductible has been reached in a Contract Year, the Company (UHI) shall insure the excess Loss per Member for Eligible Inpatient Services as specified on Schedule A hereto". "Notwithstanding the above, the maximum annual stop loss coverage payable under this agreement for Eligible Inpatient Services for each Member shall be $2,000,000."

Replaced Schedule A, Paragraph C with new levels of excess loss coverage for inpatient services exceeding the deductible amount for credentialed (Commercial 90%) and non-credentialed (80%) treatment facilities as determined by United Resource Networks.

Addendum to Schedule A, Paragraph D notes UHI "will determine no later than nine (9) months after the end of each Contract Year, the amounts of premiums and claims, for this

contract for the preceding Contract Year". This amendment was effective January 1, 2001.

Amendment No. 2: Replaced Schedule A, Paragraph C with new levels of excess loss coverage for inpatient services exceeding the deductible amount for credentialed treatment facilities as determined by United Resource Networks is 100% for Commercial and 90% for non-credentialed

The agreement was standard in form and contained acceptable clauses for insolvency, arbitration and termination. The agreement also appeared to have effectuated proper transfer of risk in accordance with NAIC guidelines.

Prior to this agreement, the Plan was afforded excess risk coverage by Lincoln National Health and Casualty Insurance Company, which is an insurance company licensed to transact business in the State of Tennessee

Effective January 1, 2005, the Plan and TDCI mutually agreed that the Plan should cease from using the Stop Loss Agreement for Mental Health and Substance Abuse ("MHSA") Services issued by UHI. Prior to January 1, 2005, the Plan was afforded the following excess loss coverage for MHSA Services as provided by UHI:

Type of Contract:	Stop Loss Agreement for Mental Health and Substance Abuse Services
Business Insured:	Eligible Mental Health and Substance Abuse Services which "shall mean lessor of (a) the amount of the Plan's fee schedule or negotiated rates for MHSA Services, or (b) the amount of Reasonable and Customary charges for MHSA services".
Term:	January 1, 2000, to continue in full force until terminated. Either party may terminate "by giving the other party written notice of such intention to terminate at least ninety (90) days prior to the anniversary of the effective date" of the agreement.
Limits and Retentions:	Commercial: 100% of eligible MHSA Services per contract year. The "maximum stop loss coverage payable under this Stop loss agreement for Eligible Inpatient Services is $1,000,000 per member."

Premium:	A flat fee for each eligible member per month is due on the 20th day of the month for which coverage is to be provided. Premiums are based on an estimate of the number of Plan members covered and eligible to receive MHSA services for the month plus an adjustment for the previous months actual versus estimated number of members.
Schedule A:	Financial: A) Premium Schedule B) Reimbursement Factor
Schedule B:	Schedule of Eligible MHSA Services
Schedule C:	Schedule of Excluded MHSA Services
Amendment No. 1:	Replaced Schedule A, Section A with Premium: Commercial: An increase in the flat fee for each eligible member per month.
Amendment No. 2:	Replaced Schedule A, Section A with Premium: Commercial: Another increase in the flat fee per eligible member per month.

TERRITORY AND PLAN OF OPERATION

The Charter dated January 13, 1995, states that "The purpose of the corporation is to do business as a health maintenance organization pursuant to Chapter 32 of Title 56, Tennessee Code Annotated." The Charter also specifies that the Plan is to be operated "for profit."

The Plan is licensed in the State of Tennessee. Its Tennessee license allows it to "transact the business of health care services, as defined in Tennessee Code Annotated, Title 56, Chapter 32." The Plan's service area at the date of this report includes the following 80 counties:

Anderson	Hamblen	Montgomery
Bedford	Hamilton	Moore
Benton	Hardeman	Obion
Bledsoe	Hardin	Overton
Blount	Haywood	Perry
Bradley	Henderson	Polk
Campbell	Hickman	Putnam
Cannon	Houston	Rhea
Carroll	Humphreys	Roane
Cheatham	Jackson	Robertson
Chester	Jefferson	Rutherford
Claiborne	Knox	Scott
Cocke	Lake	Sequatchie

Coffee	Lawrence	Sevier
Crockett	Lauderdale	Shelby
Cumberland	Lewis	Smith
Davidson	Lincoln	Stewart
Decatur	Loudon	Sumner
Dekalb	Macon	Tipton
Dickson	Madison	Trousdale
Dyer	Marion	Van Buren
Fayette	Marshall	Warren
Franklin	Maury	Wayne
Gibson	McMinn	White
Giles	McNairy	Williamson
Green	Meigs	Wilson
Grundy	Monroe	

The expansion into Hamblen and Montgomery Counties was approved by TDCI on April 16, 2001, and the expansion into Obion County was approved on July 24, 2001. The expansion into Jefferson County was approved on August 27, 2003 and the expansion into Campbell, Claiborne and Scott Counties was approved on September 2, 2003.

Hancock and Hawkins Counties were incorrectly shown as approved service areas on the Plan's 2004 annual statement. This is further discussed in this report in the section marked "Accounts and Records".

The Plan provides managed health care services to residents of Tennessee for which it receives monthly premium payments. It contracts with businesses whose employees it renders or arranges necessary medical services. The Plan offers two (2) HMO products, with varying benefit options. One (1) plan offers "out-of-network" benefits in conjunction with an HMO product in response to the enactment of Tenn. Code Ann. § 56-32-228 effective January 1, 1999.

Prior to January 1, 2000, the Plan offered a Medicare product in five (5) Tennessee Counties under a Medicare+Choice ("M+C") contract with the federal Health Care Financing Administration ("HCFA"). During the period of examination, the Plan did not participate in the Medicare risk business. This is further discussed in this report in the section marked "Subsequent Events".

As discussed under caption "Management and Control, UHCS, manages all business affairs, including marketing operations, for the Plan.

The products are marketed through a sales force of approximately 1,000 independent brokers who are appointed as authorized agents for the Plan via brokerage

agreements. These agreements provide for brokers to be paid base commissions, bonuses and "override" monetary compensation as well as non-monetary compensation based upon the number of enrolled members. A small percentage of business is produced by "general agents" who establish a network of sub-agents. Also, UHCS has entered into a limited number of national marketing and distribution agreements with national consulting firms, such as AON Consulting, Inc. that were attributable to the Plan's overall member enrollment during the period of examination. In 2004, the base and override commission payments were $3,386,671 and bonuses in the amount of $493,708 were paid to 943 producers.

The Plan contracts with physicians, hospitals and other ancillary providers to furnish health care services to its members. These contracts were reviewed for compliance with Tenn. Code Ann. § 56-32-205(c) which states that Plan members must be relieved from "any liability for services rendered by such providers except for reasonable co-payment and uncovered expenses." All contracts were found to have a "Member Protection Provision" that appears to comply with Tenn. Code Ann. § 56-32-205(c).

GROWTH OF THE PLAN

The growth of the Plan, as excerpted from annual statements, the financial statement of this report, and the December 31, 1996 and 2000 Reports of Examination, is presented as follows:

Year	Direct Written Premiums	Net Admitted Assets	Liabilities	Retained Earnings	Total Capital and Surplus
1996	$135,622,728	$24,447,606	$23,523,751	$(10,526,145)	$923,855
1997	181,033,856	41,508,028	34,337,120	(13,279,092)	7,170,908
1998	177,588,105	45,738,456	38,926,247	(24,487,875)	6,812,209
1999	181,203,304	42,402,670	31,234,816	(26,632,230)	11,167,854
2000	194,926,527	44,903,760	32,303,824	(25,200,148)	12,599,936
2001	197,502,063	43,490,787	27,632,878	(21,942,175)	15,857,909
2002	165,541,938	40,791,356	22,893,407	(19,902,135)	17,897,949
2003	138,434,514	36,208,697	13,970,778	(15,562,165)	22,237,919
2004	81,248,240	24,742,825	10,159,609	(23,216,868)	14,583,216

LOSS EXPERIENCE

The loss experience of the Plan since 1996 is presented as follows:

Year	Earned Premiums	Medical and Hospital Expenses	Loss Ratio	Administration Expenses	Loss and Experience Ratio
1996	$135,622,728	$127,870,425	94.28%	$21,343,739	110.02%
1997	183,948,856	166,056,334	90.27%	32,703,358	108.05%
1998	180,323,595	168,022,775	93.18%	29,619,667	109.60%
1999	183,150,423	162,252,885	88.59%	29,273,822	104.57%
2000	193,896,568	162,499,518	83.81%	31,286,018	99.94%
2001	195,723,767	165,218,188	84.41%	33,392,661	101.48%
2002	165,069,023	131,342,487	79.57%	31,852,596	98.86%
2003	136,892,778	101,821,163	74.38%	26,852,400	94.00%
2004	80,329,231	59,637,783	74.24%	15,315,985	93.31%

EMPLOYEE WELFARE

The Plan has no employees. As previously discussed, all business functions are performed for the Plan by UHCS, under a management agreement. Retirement and insurance benefits are provided to all personnel in the UHGI holding company system by UHCS.

LITIGATION, CONTINGENT LIABILITIES AND REGULATORY ACTION

Based upon data provided during the course of this examination, it appears that there were no matters at law in which the Plan was involved during the period under review. The examiners also noted no agreements or pending matters of a contingent nature that would materially affect its financial position or operating results as of December 31, 2004. There was no regulatory action taken by TDCI against the Plan during the period under review.

DIVIDENDS TO STOCKHOLDER

The Plan's Bylaws provide that "dividends may be declared by the board of directors, at any regular or special meeting, pursuant to law." During the period of examination in accordance with Tenn. Code Ann. § 56-11-206(b) and Tenn. Comp. R. & Reg. 0780-1-67-.17 TDCI approved the payment of two (2) extraordinary dividends to the Plans sole shareholder UHCS. In 2003, the Plan remitted a $5,000,000 extraordinary dividend and in 2004, the Plan remitted a $12,500,000 extraordinary dividend to UHCS. This is further discussed in this report in the section marked "Subsequent Events".

ACCOUNTS AND RECORDS

A review of the Plan's accounting system indicates that records appear to conform to generally accepted insurance accounting practices ("GAAP") and to accurately reflect the operations of the Plan during the period covered by this examination, except as noted below and otherwise commented upon in the section "Analysis of Changes in Financial Statement and Comments Resulting from Examination."

For each of the four (4) years covered by this examination, the Plan prepared computer-generated statutory trial balances. These balances were reconciled, proved in balance and traced to various exhibits and schedules of the respective annual statements

The Plan's information systems and data requirements are provided by UHCS under the management agreement previously discussed. UHCS utilizes two (2) primary systems for policy and claims administration, and accounts receivable processing: COSMOS and UNET. COSMOS software is maintained by Unisys Technical Support for the mainframe platform and by Unix Services & Consulting for the Unix platforms. UNET system software is maintained by IGS Systems Management which utilizes IBM mainframe computers to run the OS/390 operating system.

The Plan's investment activity is tracked by UHCS using the Portfolio Accounting Management system. Accounting records are produced from PeopleSoft software as well as from various source documents that include cash transaction records, journal entries and other specific entry documents.

UHCS has written disaster recovery plans for both the COSMOS (Unisys) and UNET systems which provide for offsite recovery. A recovery test exercise for each

system was conducted in 2004 by representatives of United Health Technologies which is a division of UHG.

The Plan's GAAP and statutory financial statements are reviewed annually as part of the audit performed for UHGI by an independent accounting firm. The independent accountants issue an annual audit report and management letter for the Plan. Any material weaknesses in the internal control structure of the Plan under standards established by the American Institute of Certified Public Accountants would be disclosed in these letters. No such weaknesses were noted in the management letter issued during the examination period.

The independent accountants also performed a review of risk-based capital ("RBC") and concluded that the Plan's total adjusted capital was in excess of the NAIC's regulatory action level and RBC requirements at December 31, 2004. A review of the RBC Report by the examiners noted that the Plan's capital was substantially above the NAIC's company action level by $9,204,466 at year-end 2004. The Plan's capital was greater than the NAIC's company action level at year-end 2003 and 2002 as noted by the 2003 and 2002 RBC Reports. However, the 2001 RBC Report noted that the Plan's capital was slightly less than the NAIC's company action level at year-end 2001.

The Plan obtains actuarial opinions on its claims reserves from a fellow of the Casualty Actuarial Society and member of the American Academy of Actuaries who is employed by UHI, an affiliate of the Plan and provider of the Plan's excess loss insurance. The Director of UHI Accounting of UHS annually signs a statement attesting that "the listings, summaries, and analyses relating to data prepared for and submitted to" the actuary "in support of his actuarial opinion" for the Plan "were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete . . .".

The following were noted in the examiner's review of the Plan's 2004 annual statement:

1. The Plan reports its premium receivables net in Part A: Assets. The NAIC has directed that the receivable be reported gross in column 1 and the non-admitted portion (from Exhibit 2, column 6) be reported in column 2.
2. Due to the fact that the Plan improperly "netted" premium receivable balances with credit balances and "bad debt reserves" the Plan did not correctly disclose the aging of premiums receivable in columns 2, 3, 4 and 5 or report non-admitted premiums due and unpaid in column 6 on Exhibit 2.

3. The Plan's $13,515 (par value) FHLMC investment held by AmSouth Capital Markets was over stated on Schedule D – Part 1 by $26,520 (par value) as compared to the $40,035 (par value) disclosed. Also, the book adjusted carrying value on Schedule D – Part 1 was overstated by approximately $26,000.
4. Hancock and Hawkins counties were incorrectly shown as "service areas in which reporting entity is licensed to operate" in response to question 12, under the "General Interrogatories – Part 2 – Health Interrogatories" section of the 2004 annual statement.

In light of the aforementioned exceptions, the Plan did not disclose a completely accurate 2004 annual statement in accordance with Tenn. Code Ann. § 56-32-208, that requires an annual statement report be filed "on the blank prescribed by the National Association of Insurance Commissioners for health maintenance organizations". In addition, Tenn. Comp. R. & Regs., 0780-1-28.01 requires all reports "shall be prepared in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual in effect for the period covered by the report". See the "Recommendations" section of this report.

SUBSEQUENT EVENTS

Custodian Agreement

Subsequent to the December 31, 2004 date of examination the Plan and UHG executed a new custodial agreement with State Street Bank that contained the proper provisions as required by Tenn. Comp. R. & Regs., 0780-1-46.04. This new custodial agreement was signed by authorized representatives of UHG and the Plan on October 14, 2005 and State Street Bank on October 19, 2005. See the "Recommendations" section of this report for further information.

Dividends

Subsequent to the period of examination the TDCI in accordance with Tenn. Code Ann. § 56-11-206(b) and Tenn. Comp. R. & Reg. 0780-1-67-.17 approved the payment of an $8,600,000 extraordinary dividend on August 29, 2005, to the Plan's sole shareholder UHCI.

Territory and Plan of Operation

Subsequent to the period of examination and effective January 1, 2005, the Plan offered a Medicare product in Davidson, Rutherford, Hickman and Dekalb counties in Tennessee under a Medicare Complete contract with the federal Health Care Financing Administration (HCFA). Also, the Plan effective August 1, 2005, began offering a Medicare Complete Essential Private Fee for Service product in Carter, Sullivan and Unicoi counties in Tennessee.

Merger and Acquisition

Subsequent to the period of examination, UHG announced on December 6, 2005, of its plans to purchase John Deere Health Care for $500 million in cash, conditional upon regulatory approval from state and federal agencies. John Deere Health Care owns 100% of John Deere Health Plan, Inc., an Illinois domiciled HMO that is licensed and conducts business in Tennessee.

Financial Statement

There follows a statement of assets, liabilities and a summary of operations as of December 31, 2004, together with a reconciliation of capital and surplus for the period under review, as established by this examination.

Assets

	Ledger Assets	Non-Ledger Assets	Non-Admitted Assets	Net-Admitted Assets
Bonds	$14,845,355	$0	$0	$14,845,355
Cash, Cash Equivalents and Short-Term Investments	8,735,355	0	0	8,735,355
Investment Income Due and Accrued	230,577	0	0	230,577
Uncollected Premiums	557,065	0	215,337	341,728
Net Deferred Tax Asset	103,978	0	0	103,978
Receivable from Parent, Subsidiaries and Affiliates	485,832	0	0	485,832
Health Care Receivable	112,254	0	112,254	0
Totals	$25,070,416	$0	$327,591	$24,742,825

Liabilities, Surplus and Other Funds

Claims Unpaid		$7,794,383
Aggregate Health Policy Reserves		76,665
Aggregate Health Claim Reserves		287,427
Premiums Received in Advanced		902,258
General Expenses Due or Accrued		429,970
Current Federal and Foreign Income Tax Payable		78,897
Amounts Withheld or Retained for the Account of Others		72,228
Liability for Amounts Held Under Uninsured Accident and Health Plans		10,431
Aggregate Write-ins for Other Liabilities:		
Unapplied Premium Overpayments		192,132
Allowance for Premium Retroactivity		231,513
Allowance for Uncollectible Premium		83,705
Total Liabilities		10,159,609
Common Capital Stock	$100,000	
Gross Paid in and Contributed Surplus	37,700,084	
Unassigned Funds (Surplus)	(23,216,868)	
Surplus as Regards Policyholders		14,583,216
Total		$24,742,825

Summary of Operations

Net Premium Income	$80,329,231	
Change in Unearned Premium Reserves and Reserve for Rate Credits	41,320	
Total Premium Revenue		$80,370,551
Hospital / Medical Benefits	52,449,304	
Other Professional Services	104,914	
Prescription Drugs	7,404,127	
Gross Total Hospital and Medical		59,958,345
Net Reinsurance Recoveries	320,562	
Net Total Hospital and Medical		59,637,783
Claims Adjustment Expenses	2,013,481	
General Administrative Expenses	13,302,504	
Increase in Reserves for Life and Accident and Health Contracts	(59,834)	
Total Claims and General Administrative Expenses		15,256,151
Total Underwriting Deductions		74,893,934
Net Underwriting Gain or (Loss)		5,476,617
Net Investment Income Earned	1,165,037	
Net Realized Capital Gains or (Losses)	537,166	
Net Investment Gains		1,702,203
Net Income or (Loss) Before Federal Income Taxes		7,178,820
Federal Income Taxes Incurred		2,164,000
Net Income (Loss)		$5,014,820

Capital and Surplus Account

	2001	2002	2003	2004
Surplus as Regards Policyholders, December 31, Previous Year	$12,599,937	$15,857,910	$17,897,950	$22,237,920
Net Income	857,210	2,082,496	9,817,936	5,014,820
Change in Deferred Income Tax	0	155,605	(924,156)	(157,493)
Change in Non-Admitted Assets	1,206,285	(198,061)	446,190	203,306
Change in Surplus Notes	0	0		0
Cumulative Effect of Changes in Accounting Principals	1,194,478	0	0	0
Capital Changes: Paid in	0	0		
Surplus Adjustments: Paid in	0	0		
Change in Asset Maintenance Reserve	0	0	0	0
Dividends to Stockholder	0	0	(5,000,000)	(12,500,000)
Aggregate Write-Ins for Gains and Losses in Surplus	0	0	0	(215,337)
Net Change for the Year	3,257,973	2,040,040	4,339,970	(7,654,704)
Surplus as Regards Policyholders, December 31, Current Year	$15,857,910	$17,897,950	$22,237,920	$14,583,216

Analysis of Changes in Financial Statement and Comments Resulting From Examination

Assets

Bonds **$14,845,355**

The above balance is the amount reflected by the Plan in its 2004 annual statement. However, the $13,515 (par value) FHLMC investment held by AmSouth Capital Markets was over stated on Schedule D – Part 1 by $26,520 (par value) as compared to the $40,035 (par value) disclosed. Also, the book adjusted carrying value on Schedule D – Part 1 was overstated by approximately $26,000. The differences represent immaterial amounts and no changes will be made per this examination.

Uncollected Premiums and Agents' Balances in Course of Collection **$341,728**

The above amount is $292,014 more than the $49,714 net-admitted amount and $507,351 more than the $49,714 gross admitted amount reported by the Plan in its 2004 annual statement. The $215,337 difference is considered a non-admitted asset and Unassigned Funds (Surplus) is reduced accordingly. As directed by Tenn. Code Ann. § 56-32-208 and *NAIC Accounting Practices and Procedures* the Examiners recalculated the individual receivable accounts with net credit balances separated and established the full value of this asset without the netting of any "bad debt" and "premium retroactivity" reserves established by the Plan. Also, the Examiners individually accounted for the net credit balances, "bad debt" and "premium retroactivity" reserves by the creation of three (3) separate "Aggregate Write-In For Other Liabilities" items described as "Unapplied Premium Overpayments", "Allowance for Uncollectible Premium" and "Allowance for Premium Retroactivity". See the corresponding "Analysis of Changes in Financial Statement" and the "Summary Schedule for Analysis of Changes in Financial Statement" for a further description. Additional comments are found in this Examination Report under the "Recommendations" section.

Liabilities

Unapplied Premium Overpayments **$192,132**

This $192,132 amount was established by the Examiners as an "Aggregate Write-In For Other Liabilities" item for disclosure purposes within this Examination Report. Contrary to *NAIC Accounting Practices and Procedures*, it was the practice of the Plan to net accounts that have credit balances with accounts that have "true" receivable balances on the policy level and disclose them in aggregate as uncollected for less than 30 days for year-end 2004 reporting purposes. This method diluted the actual premium receivable value on the whole as well as the "gross" amounts due in the different aging groups shown on Exhibit 2 in the annual statement. This treatment of credit balances was noted by the Plan's independent accounting firm as causing the 2003 and 2004 financial statements to be misstated. Plan management acknowledged the misstatements but deemed the amounts in question as immaterial and continued to report improperly.

Allowance for Premium Retroactivity **$231,514**

This $231,514 amount was established by the Examiners as an "Aggregate Write-In For Other Liabilities" item for disclosure purposes within this Examination Report. The Plan further complicated their reporting of uncollected premiums by offsetting the remaining premium balances (net of credit and uncollected balances) with a "bad debt" and a "premium retroactivity" reserve for contingencies. The Plan in their presentation of Exhibit 2 in the annual statement did not "write off" the uncollected amounts covered by the reserves but netted them against the receivable balance for reporting purposes beginning with the oldest receivable balances until the reserves were fully allocated. Presentation of Exhibit 2 in the 2004 annual statement in this manner gave the false impression that the Plan had no uncollected premium amounts over 30 days and thus did not have any amounts to be non-admitted. Since this is not a permitted *NAIC Accounting Practices and Procedures,* the Examiners determined that reserves should not be netted against receivable balances but the full value of the receivable should be disclosed and the existing reserve accounts should be presented separately as a liability. However, the Plan has the option of completely "writing off" the premium receivable balances against the reserves and reporting the gross amount of uncollected premiums in column 1 and the

non-admitted portion in column 2 on the Assets page and fully disclosing the net admitted aging of uncollected premiums and the non-admitted portion on Exhibit 2 in the annual statement.

Allowance for Uncollectible Premium **$83,705**

This $83,705 amount was established by the Examiners as an "Aggregate Write-In For Other Liabilities" item for disclosure purposes within this Examination Report. See the "Allowance for Premium Retroactivity" "Analysis of Changes in Financial Statement" Examination change comment referenced above for an explanation of this "write-in" liability item.

Summary Schedule for "Analysis Of Changes In Financial Statement"

The following depicts the change in surplus as outlined in the previous section of this report:

Item	Surplus	
	Increase	Decrease
Uncollected Premiums and Agents' Balances in Course of Collection	$292,014	
Unapplied Premium Overpayments		$192,132
Allowance for Premium Retroactivity		231,514
Allowance for Uncollected Premium		83,705
Totals	$292,014	$507,351
Net change in surplus		$215,337

Comments

Statutory Deposits

The descriptions for par value, statement value and market value of the deposits pledged to TDCI were overstated by approximately $40,035 on Schedule E – Part 3 – Special Deposits in the 2004 annual statement. The Plan correctly reported these values on Schedule D; therefore, the amounts were not misstated in the Plan's financial statements. See the "Statutory Deposits" section of this report for further information.

Professional Liability Policy

It was noted earlier in the examination report that H & W Indemnity, Ltd. provided the Plan coverage through a Managed Care Professional Liability Policy. H & W Indemnity, Ltd. was not a licensed insurance carrier or an approved alien or foreign surplus lines carrier in the State of Tennessee as of the date of this examination. The Plan should refrain from entering into any additional contracts with H & W Indemnity, Ltd. as long as they remain unlicensed and unapproved in Tennessee.

Recommendations

Uncollected Premiums

The Plan did not fully disclose the gross amount of uncollected premiums in column 1 and the non-admitted portion in column 2 on the Asset section in the 2004 annual statement. Furthermore, the Plan did not fully disclose the aging of uncollected premiums and the non-admitted portion on Exhibit 2 in the 2004 annual statement as required by Tenn. Code Ann. § 56-32-208, Tenn. Comp. R. & Regs., 0780-1-28.01, *NAIC Accounting Practices and Procedures* and *NAIC Annual Statement Instructions*.

The Plan should comply with Tenn. Code Ann. § 56-32-208, Tenn. Comp. R. & Regs., 0780-1-28.01, *NAIC Accounting Practices and Procedures* and *NAIC Annual Statement Instructions* when disclosing gross and non-admitted premiums and the aging of uncollected premiums in future reports submitted to TDCI.

Custodian Agreement

As noted previously in the examination report the Plan participated in an "Amended and Restated Custodian Agreement" by and between UHG and State Street Bank. This agreement did not meet two (2) specific requirements set forth in Tenn. Comp. R. & Regs., 0780-1-46.04. (1) The Agreement did not have a specific provision requiring a "standard or responsibility on the part of the custodian which shall not be less than the responsibility of a bailee for hire or a fiduciary under statutory or case law of Tennessee". (2) The Agreement did not contain concise language allowing the "Participant" to withdraw securities immediately upon demand subject to instructions of the "Participant". During the examination it was recommended that the Plan take immediate action to execute a revised custodial agreement in order to add the aforementioned specific terms required by Tenn. Comp. R. & Regs., 0780-1-46.04. See the "Subsequent Events" section of this report for corrective actions taken by the Plan.

Conclusion

The customary insurance examination practices and procedures, as promulgated by the NAIC, have been followed in connection with the verification and valuation of assets and the determination of the liabilities of the Plan.

In such manner, it was found that as of December 31, 2004, the Plan had admitted assets of $24,742,825 and liabilities, exclusive of capital and surplus, of $10,159,609. Thus, there existed for the additional protection of the policyholders, the amount of $14,583,216 in the form of paid up capital, gross paid in and contributed surplus and unassigned funds (surplus).

The courteous cooperation of the officers and employees working on behalf of the Plan extended during the course of examination is hereby acknowledged.

In addition to the undersigned, Michael W. Lamb, Examiner II, State of Tennessee participated in the work of this examination.

Respectfully submitted,

James T. Pearce, Jr.

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Examiner-in-charge
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Southeastern Zone, NAIC

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Examination Affidavit

The undersigned deposes and says that he has duly executed the attached examination report of the United HealthCare of Tennessee, Inc., dated April 27, 2006, and made as of December 31, 2004, on behalf of "The Tennessee Department of Commerce and Insurance". Deponent further says he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.

James T. Pearce, Jr.

James T. Pearce, Jr.
Examiner-in-Charge
State of Tennessee
Southeastern Zone, NAIC

County Davidson
State TN

Subscribed and sworn to before me
this 27th day of
April, 2006

Chrissy Brown
(Notary)

CHRISSY BROWN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires
July 25, 2009

Corporations and LLCs are shown in rectangles.
Partnerships are shown in triangles.

As of Dec. 31, 2004

MN (1)(29)
UNITEDHEALTH GROUP INCORPORATED

Continued

DE 100%
Golden Rule Financial Corporation

IN 100%(5)
Golden Rule Acquisition Corporation

AL 100%
Great Western Products Company, Inc.

TN 100%
Active Transportation, LLC

IL 100%(22)
Golden Rule Insurance Company (Ins.)
NAIC No. 62286

IN 100%(27)
All Savers Insurance Company (Ins.)
NAIC No. 82406

CA 100%(42)(5)
Rooney Life Insurance Company (Ins.)
NAIC No. 73130

IN 100%
Ad-Ventures, Inc.

IN 100%
Charitable Organizations Services, Inc.

DE 100%(5)
Executive Systems, Inc.

DE 100%(52)
Mid Atlantic Medical Services, LLC

MD 100%(53)
Optimum Choice, Inc. (HMO)
NAIC No. 96940

NC 100%(54)
Optimum Choice of the Carolinas, Inc. (HMO)
NAIC No. 95312

PA 100%(5)
Optimum Choice, Inc. of Pennsylvania (HMO)
NAIC No. 95225

MD 100%(55)
Alliance Recovery Services, LLC

MD 100%(56)
MAMSI Life and Health Insurance Company (Ins.)
NAIC No. 60321

MD 100%(57)
Alliance PPO, LLC

MD 100%(58)
MAMSI Insurance Resources, LLC

NC 100%(58)
MAMSI Insurance Agency of the Carolinas

MD 100%
Physicians Health Plan of Maryland, Inc.

MD 76.7%(63)
MD-Individual Practice Association, Inc. (HMO) (FQ)
NAIC No. 96310

MD 100%
MD-IPA Surgicenter, Inc.

MD 100%
HomeCall Hospice Services, Inc.

MD 100%(59)
HomeCall Pharmaceutical Services, Inc.

MD 100%(60)
HomeCall, Inc.

MD 100%(62)
FirstCall, Inc.

MO 100%
MLH Life Trust

DE 100%(15)(73)
Oxford Health Plans LLC

CA 100%(74)
Investors Guaranty Life Insurance Company (Ins.)
NAIC No. 64890

CT 100%(75)
Oxford Health Plans (CT), Inc. (HMO)
NAIC No. 96798

NJ 100%
Oxford Health Plans (NJ), Inc. (HMO)
NAIC No. 95506

CT 100%
Oxford Benefit Management, Inc.

DE 100%
Oxford Aviation, Inc.

NY 100%
Oxford Health Plans (NY), Inc. (HMO)
NAIC No. 95479

NY 100%(76)
Oxford Health Insurance, Inc. (Ins.)
NAIC No. 78026

MN 100% (13)(14)(15)(16)(78)
United HealthCare Services, Inc.

DE 100%
Fidelity Insurance Group Inc.

MD 100%(72)
Fidelity Insurance Company (Ins.)
NAIC No. 43010

MD 100%(15)(16)
Fidelity Benefit Administrators, Inc.

MD 100%
Physicians Medical Group, Inc.

DE 100%(26)
UnitedHealthcare, Inc.

AL 100%(15)
United HealthCare of Alabama, Inc. (HMO) (M+CO)
NAIC No. 95784

AZ 100%
United HealthCare of Arizona, Inc. (HMO)
NAIC No. 96016

AZ 100%
Arizona Physicians IPA, Inc.

AR 100%(16)
United HealthCare of Arkansas, Inc. (HMO)
NAIC No. 95446

CO 100%
United HealthCare of Colorado, Inc. (HMO)
NAIC No. 95090

FL 100%
United HealthCare of Florida, Inc. (HMO) (M+CO)
NAIC No. 95264

GA 100%
United HealthCare of Georgia, Inc. (HMO)
NAIC No. 95850

IL 100%(7)
UnitedHealthcare of Illinois, Inc. (HMO)(FQ)
NAIC No. 95776

LA 100%(15)(16)
United HealthCare of Louisiana, Inc. (HMO)
NAIC No. 95833

MD 100%(21)
UnitedHealthcare of the Mid-Atlantic, Inc. (HMO)
NAIC No. 95025

NE 100%(8)
United HealthCare of the Midlands, Inc. (HMO) (M+CO)
NAIC No. 95591

MO 100%(11)
United HealthCare of the Midwest, Inc. (HMO) (M+CO)
NAIC No. 96385

MS 100%
United HealthCare of Mississippi, Inc. (HMO)
NAIC No. 95716

NJ 100%
UnitedHealthcare of New Jersey, Inc. (HMO)
NAIC No. 95080

NY 100%
UnitedHealthcare of New York, Inc. (HMO)
NAIC No. 95085

NC 100%
UnitedHealthcare of North Carolina, Inc. (HMO) (M+CO)
NAIC No. 95103

TN 100%(15)
United HealthCare of Tennessee, Inc. (HMO)
NAIC No. 11147

TX 100%(16)
United HealthCare of Texas, Inc. (HMO)
NAIC No. 95765

UT 95.67%
United HealthCare of Utah (HMO)
NAIC No. 95501

WI 100%
UnitedHealthcare of Wisconsin, Inc. (HMO) (M+CO)
NAIC No. 95710

WI 100%(35)
Midwest Security Holding, Inc.

WI 100%(16)
Midwest Security Administrators, Inc.

WI 100%(15)
Midwest Security Care, Inc.

WI 100%(71)
Midwest Security Life Insurance Company (Ins.)
NAIC No. 79480

RI 100%(9)(15)
UnitedHealthcare of New England, Inc. (HMO) (M+CO)
NAIC No. 95149

OH 100%(2)
United HealthCare of Ohio, Inc. (HMO) (M+CO)
NAIC No. 95186

UK 100%
UnitedHealth Europe Limited

KY 98.59% (15)(24)
United HealthCare of Kentucky, Ltd. (HMO)
NAIC No. 96644

DE 100%(38)
UnitedHealth Networks, Inc.

DE 100%
UnitedHealth Capital, LLC

KY 100%
Commonwealth Physicians Services Corporation

DE 100%
Exante Financial Services, Inc.

UT 100%
Exante Bank, Inc.

DE 100%(65)
UHIC Holdings, Inc.

CT 100%(30)(14)(15)
United HealthCare Insurance Company (Ins.)
NAIC No. 79413

IL 100%(33)
United HealthCare Insurance Company of Illinois (Ins.)
NAIC No. 60318

NY 100%(32)
United HealthCare Insurance Company of New York (Ins.)
NAIC No. 60093

OH 100%(31)
United HealthCare Insurance Company of Ohio (Ins.)
NAIC No. 73518

NY 100%(36)
Unimerica Life Insurance Company of New York
NAIC No. 11596

DE 100%
United HealthCare Products, LLC

DE 100%(16)
United HealthCare Service LLC

DE 100%(10)
UnitedHealthcare Alliance LLC

SC 100%
Duncan Printing Services, LLC

DE 100%(15)(16)
Uniprise, Inc.

DE 100%
HealthAllies, Inc.

DE 100%(16)(58)
Definity Health Corporation

MN 100%(5)
Definity Health of New York, Inc.

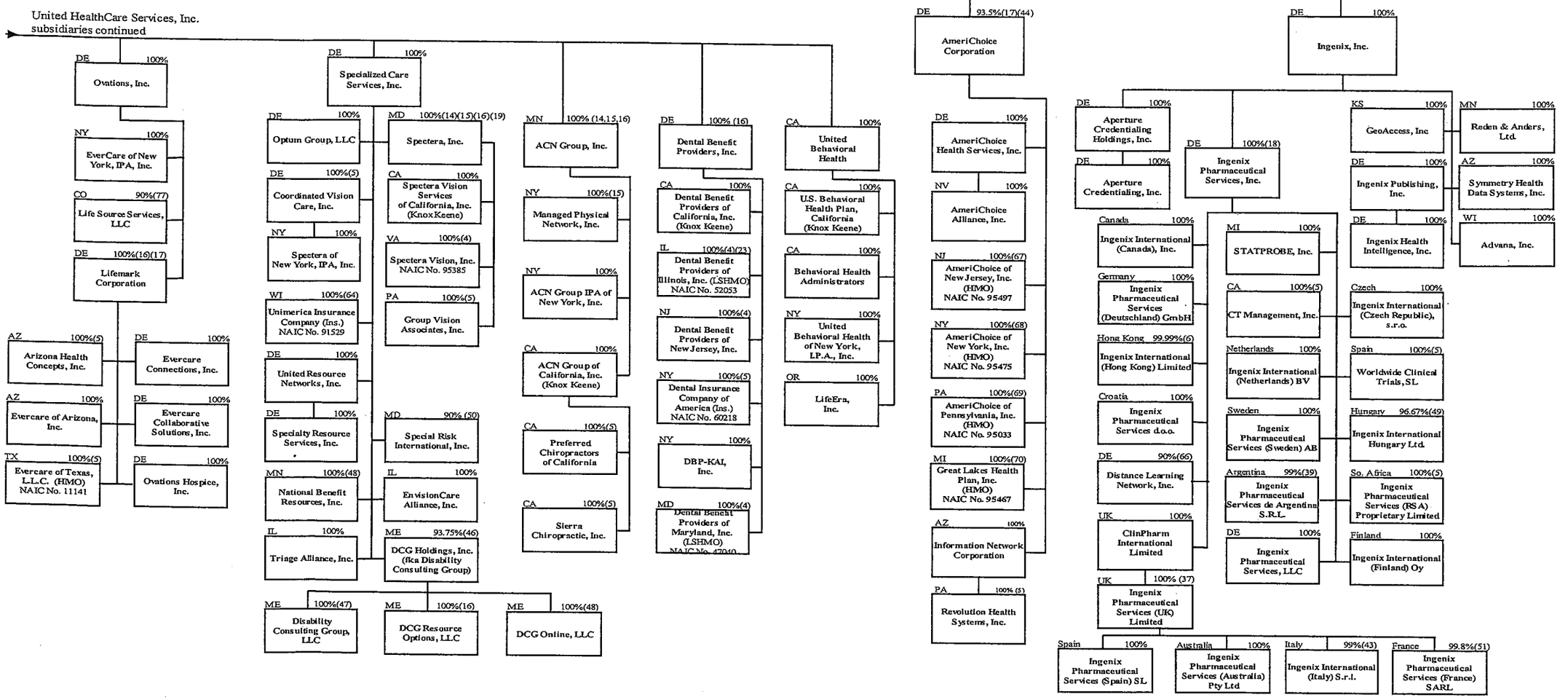
MN 100%(5)
Lemhi Corporation

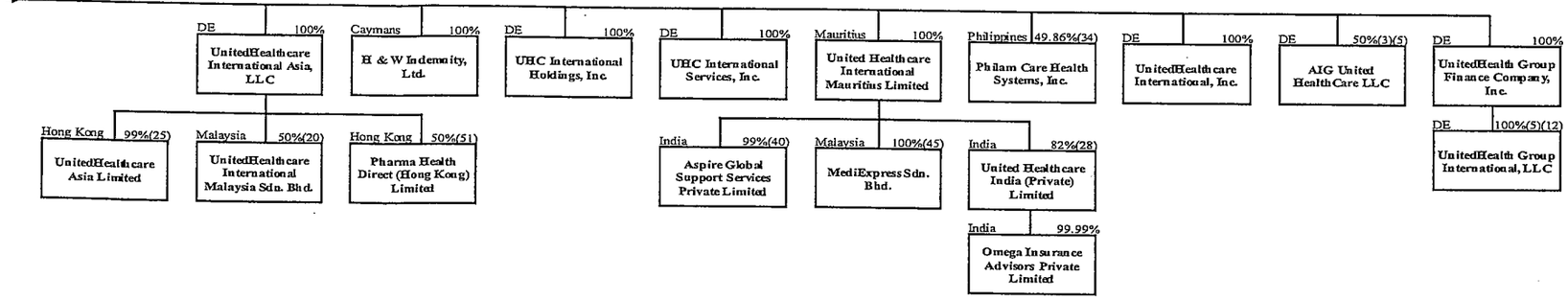
As of Dec. 31, 2004

UnitedHealth Group Incorporated
subsidiaries continued

Continued

United HealthCare Services, Inc.
subsidiaries continued



UnitedHealth Group Incorporated
subsidiaries continued

As of Dec. 31, 2004