MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

RICKY DAVIS
State Chief Deputy Fire Marshal

MISSISSIPPI INSURANCE DEPARTMENT

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, Mississippi 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 359-2474

June 15, 2023

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. James M. Parnell, CEO and President
United Healthcare of Mississippi, Inc.
795 Woodlands Parkway
Suite 301
Ridgeland, MS 39157

RE: Report of Examination as of December 31, 2021

Dear Mr. Parnell:

In accordance with Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2022), an examination of your Company has been completed. Enclosed herewith is the Order adopting the report and a copy of the final report as adopted.

Pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2022), the Mississippi Department of Insurance shall continue to hold the content of said report as private and confidential for a period of ten (10) days from the date of the Order. After the expiration of the aforementioned 10-day period, the Department of Insurance will open the report for public inspection.

If you have any questions or comments, please feel free to contact me.

Sincerely,

MIKE CHANEY
COMMISSIONER OF INSURANCE

BY _____
Christina J. Kelsey
General Counsel

MC/CK/de
Encls. Order w/exhibit

BEFORE THE COMMISSIONER OF INSURANCE
OF THE STATE OF MISSISSIPPI

RE: REPORT OF EXAMINATION OF UNITED HEALTHCARE OF MISSISSIPPI, INC. **CAUSE NO. 23-7806**

ORDER

THIS CAUSE came on for consideration before the Commissioner of Insurance of the State of Mississippi ("Commissioner"), or his designated appointee, in the Offices of the Commissioner, 1001 Woolfolk Building, 501 North West Street, 10th Floor, Jackson, Hinds County, Mississippi, pursuant to Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2022). The Commissioner, having fully considered and reviewed the Report of Examination together with any submissions or rebuttals and any relevant portions of the examiner's work papers, makes the following findings of fact and conclusions of law, to-wit:

JURISDICTION

I.

That the Commissioner has jurisdiction over this matter pursuant to the provisions of Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2022).

II.

That United HealthCare of Mississippi, Inc. is a Mississippi-domiciled health maintenance organization ("HMO") which was initially certified as an HMO by the Mississippi State Department of Health on June 1, 1992, under the name Complete Health of Mississippi, Inc. ("CHM"). Effective May 1, 1996, the Articles of Incorporation of CHM resolved to change the name of the corporation to United HealthCare of Mississippi, Inc.

FINDINGS OF FACT

III.

That the Commissioner, or his appointee, pursuant to Miss. Code Ann. §§ 83-5-201 et seq. and 83-41-337(1) (Rev. 2022), called for an examination of United HealthCare of Mississippi, Inc. and appointed Vitaliy Kyryk, Examiner-In-Charge, to conduct said examination.

IV.

That on or about May 11, 2023, the draft Report of Examination concerning United HealthCare of Mississippi, Inc. for the period of January 1, 2017, through December 31, 2021, was submitted to the Mississippi Department of Insurance by Examiner-In-Charge, Vitaliy Kyryk.

V.

That on or about May 25, 2023, pursuant to Miss. Code Ann. § 83-5-209(2) (Rev. 2022), the Department forwarded to the Company a copy of the draft report and allowed the Company a 15-day period to submit any rebuttal to said draft. The Company responded in an email on or about May 31, 2023.

CONCLUSIONS OF LAW

VII.

The Commissioner, pursuant to Miss. Code Ann. § 83-5-209(3) (Rev. 2022), must consider and review the report along with any submissions or rebuttals and all relevant portions of examiner work papers and enter an Order: (1) adopting the Report of Examination as final or with modifications or corrections; (2) rejecting the Report of Examination with directions to reopen; or (3) calling for an investigatory hearing.

IT IS, THEREFORE, ORDERED, after reviewing the draft Report of Examination and all relevant examiner work papers, that the draft Report of Examination of United HealthCare of Mississippi, Inc., attached hereto as Exhibit "A", should be and same is hereby adopted as final.

IT IS FURTHER ORDERED that a copy of the adopted Report of Examination, accompanied with this Order, shall be served upon the Company by certified mail, postage pre-paid, return receipt requested.

IT IS FURTHER ORDERED that the Mississippi Department of Insurance shall continue to hold the content of this report as private and confidential information for a period of ten (10) days from the date of this Order, pursuant to Miss. Code Ann. § 83-5-209(6)(a) (Rev. 2022).

IT IS FURTHER ORDERED, pursuant to Miss. Code Ann. § 83-5-209(4) (Rev. 2022), that within thirty (30) days of the issuance of the adopted report, United HealthCare of Mississippi, Inc. shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

IT IS FURTHER ORDERED that United HealthCare of Mississippi, Inc. take the necessary actions and implement the necessary procedures to ensure that all recommendations contained in the Report of Examination are properly and promptly complied with.

SO ORDERED, this the 15th day of June 2023.

J. Mark Haire

J. MARK HAIRE
DEPUTY COMMISSIONER OF INSURANCE
STATE OF MISSISSIPPI

COMMISSIONER OF INSURANCE
MISSISSIPPI

CERTIFICATE OF MAILING

I hereby certify that a true and correct copy of the above and foregoing Order and a copy of the final Report of Examination, as adopted by the Mississippi Department of Insurance, was sent by certified mail, postage pre-paid, return receipt requested, on this the 5th day of June 2023, to:

Mr. James M. Parnell, CEO and President
United Healthcare of Mississippi, Inc.
795 Woodlands Parkway
Suite 301
Ridgeland, MS 39157

Christina J. Kelsey
General Counsel

Christina J. Kelsey
General Counsel
Counsel for the Mississippi Department of Insurance
Post Office Box 79
Jackson, MS 39205-0079
(601) 359-3577
Miss. Bar No. 9853

Mississippi Insurance Department

Report of Examination

of

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

as of

December 31, 2021

TABLE OF CONTENTS

EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION

State of Indiana,

County of Marion,

Vitaliy Kyryk, being duly sworn, states as follows:

1. I have authority to represent the Mississippi Insurance Department in the examination of UnitedHealthcare of Mississippi, Inc. as of December 31, 2021.

2. The Mississippi Insurance Department is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation.

3. I have reviewed the examination work papers and examination report, and the examination of UnitedHealthcare of Mississippi, Inc. was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners and the Mississippi Insurance Department.

The affiant says nothing further.

Vitaliy Kyryk
Examiner-In-Charge

Subscribed and sworn before me by Vitaliy Kyryk on this 24th day of May, 2023.

(SEAL)

DIANNE DEITCH
Notary Public - Seal
Madison County - State of Indiana
Commission Number NP0725200
My Commission Expires Feb 16, 2028

Notary Public

My commission expires 2-16-2028 [date].

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

MISSISSIPPI INSURANCE DEPARTMENT
501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, MS 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 576-2568

April 13, 2023

Honorable Mike Chaney
Commissioner of Insurance
Mississippi Insurance Department
1001 Woolfolk Building
501 North West Street
Jackson, Mississippi 39201

Dear Commissioner Chaney:

Pursuant to your instructions and authorization and in compliance with statutory provisions, an examination has been conducted, as of December 31, 2021, of the affairs and financial condition of:

UNITEDHEALTHCARE OF MISSISSIPPI, INC.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

License #	NAIC Group #	NAIC #	FEETS#	MATS#
9500034	0707	95716	95716-MS-2021-2	MS-MS099-40

This examination was commenced in accordance with Miss. Code Ann. § 83-5-201 and § 83-41-337. The report of examination is herewith submitted.

SCOPE OF EXAMINATION

We have performed our full-scope, single state examination of UnitedHealthcare of Mississippi, Inc. ("UHCMS" or "Company") as part of a coordinated examination, including 19 states and 34 legal entities, conducted by the lead state of Connecticut. The last examination covered the period of January 1, 2012 through December 31, 2016. This examination covers the period of January 1, 2017 through December 31, 2021.

We conducted our examination in accordance with the NAIC *Financial Condition Examiners Handbook* ("Handbook"). The Handbook requires that we plan and perform the examination to evaluate the financial condition, assess corporate governance, identify current and prospective risks of the Company and evaluate system controls and procedures used to mitigate those risks. An examination also includes identifying and evaluating significant risks that could cause an insurer's surplus to be materially misstated both currently and prospectively.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process. This may include assessing significant estimates made by management and evaluating management's compliance with Statutory Accounting Principles. The examination does not attest to the fair presentation of the financial statements included herein. If, during the course of the examination, an adjustment is identified, the impact of such adjustment will be documented separately following the Company's financial statements.

This examination report includes significant findings of fact, in accordance with Miss. Code Ann. § 83-5-209 and general information about the insurer and its financial condition. There may be other items identified during the examination that, due to their nature (e.g., subjective conclusions, proprietary information, etc.), are not included within the examination report but separately communicated to other regulators and/or the Company.

COMMENTS AND RECOMMENDATIONS OF PREVIOUS EXAMINATION

There were no comments and/or recommendations deemed necessary for purposes of the previous examination report.

HISTORY OF THE COMPANY

The Company was incorporated on August 6, 1990 as Complete Health of Mississippi, Inc. ("CHM"), under the laws of the State of Mississippi. The Mississippi State Department of Health issued CHM a certificate of authority as a health maintenance organization (HMO) on June 1, 1992, and the Company commenced operations on January 1, 1993.

CHM became a member of the insurance holding company system of UnitedHealth Group, Incorporated ("UHG"), formerly known as United HealthCare Corporation, on May 31, 1994 with UHG's acquisition of United HealthCare South, Inc. ("UHC South"), formerly known as Complete Health Services, Inc., an Alabama corporation and sole shareholder of the Company. On April 30, 1996, UHG contributed the shares of UHC South to United HealthCare Services, Inc. ("UHS"), a Minnesota Corporation and wholly owned subsidiary of UHG, a Delaware corporation and a publicly traded, diversified health company.

The Company changed its name to United HealthCare of Mississippi, Inc., effective May 1, 1996. Effective January 2, 1998, UHC South was merged into UHS, and the Company became a wholly owned subsidiary of UHS, who maintained control through its sole ownership of all issued and outstanding shares of the Company. On June 30, 2000, the Company's shares were transferred from UHS to UnitedHealthcare, Inc. ("UHC"), a Delaware corporation and wholly owned subsidiary of UHS. The Company changed the appearance of its name to UnitedHealthcare of Mississippi, Inc. on December 22, 2010, by filing Articles of Amendment to its Articles of Incorporation.

CORPORATE RECORDS

The Articles of Incorporation, Bylaws and amendments thereto were reviewed and duly applied in other sections of this report where appropriate. Minutes of the meetings of the Shareholder, Board of Directors ("Board"), and various committees, as recorded during the period covered by this examination, were reviewed and appeared to be complete and in order with regard to actions brought up at the meetings for deliberation and appropriate action, which included the approval and support of the Company's transactions and events, as well as the review of the audit and examination report.

MANAGEMENT AND CONTROL

Stockholders

The Bylaws of the Company, as amended on December 22, 2010, to reflect the name change of the Company, provide that annual meetings of shareholders shall be held on the fourth Thursday in March, or at such other date and time as shall be designated from time to time by the Board and stated in the notice of meeting, at which they shall elect a Board by a plurality vote. A quorum is constituted as a majority of the votes entitled to be cast, represented in person or by proxy. The shareholder may also take action without a meeting if one or more consents in writing are signed by

all of the shareholders entitled to vote. All action taken by the sole shareholder during the period under examination was by unanimous written consent.

Board of Directors

The Articles of Incorporation and Bylaws vest the management and control of the Company's business affairs with the Board. The members of the duly elected Board, along with their place of residence, number of years as Director, and principal occupation as of December 31, 2021, were as follows:

Name and Residence	Year Elected / Appointed	Principal Occupation
Chandler A. Ewing Madison, MS	2021	Executive – Director – Finance, Community & State United HealthCare Services, Inc.
Christine D. O'Brien New Orleans, LA	2020	Executive – Vice President, General Management United HealthCare Services, Inc.
James M. Parnell Ridgeland, MS	2021	Executive – Health Plan CEO, Community & State-Central Region United HealthCare Services, Inc.

Committees

The Bylaws of the Company provide that the Board, by resolution adopted by a majority of the number of directors fixed by the bylaws or otherwise, may create one or more committees and appoint members of the Board to serve on them. Additionally, each committee must have two or more members, who serve at the pleasure of the Board. There were no committees established during the examination period, solely for the operations and activities of UHCMS.

As contemplated by the Charter of the UHS Audit Committee and pursuant to the Annual Financial Reporting Regulations promulgated by the NAIC and adopted by the relevant states (the "Model Audit Rule"), the Southeast Region UHS Audit Committee has been designated as the audit committee for UHCMS. The Audit Committee, in coordination with UHG, is responsible for supervising audit work and reviewing the audit report prepared by the outside accounting firm. The committee also makes recommendations to the Board regarding the report and the selection of an outside accounting firm. The committee is also responsible for overseeing the Company's compliance with the Model Audit Rule and for ensuring management establishes, implements, and monitors a system of internal controls over financial reporting. The Southeast Region Audit Committee provides coverage for multiple legal entities including UHCMS, consisting of three members, two of which are outside directors, and meets quarterly or as needed. The members of the committee, along with their relationship to the Company, and principal occupation as of December 31, 2021, were as follows:

Name	Occupation
Christopher Kreutzer (Chair)	Executive – Vice President, Accounting United HealthCare Services, Inc.
Eric Johnson	Executive – Vice President, Finance; Employer & Individual United HealthCare Services, Inc.
Alissa Weber	Executive – Vice President, Finance; Community & State United HealthCare Services, Inc.

Officers

Name	Year Elected / Appointed	Title
James M. Parnell	2021	Chief Executive Officer and President
Chandler A. Ewing	2021	Chief Financial Officer
Peter M. Gill	2018	Treasurer
Heather A. Lang	2015	Assistant Secretary
Jessica L. Zuba	2017	Assistant Secretary
Nyle B. Cottington	2015	Vice President

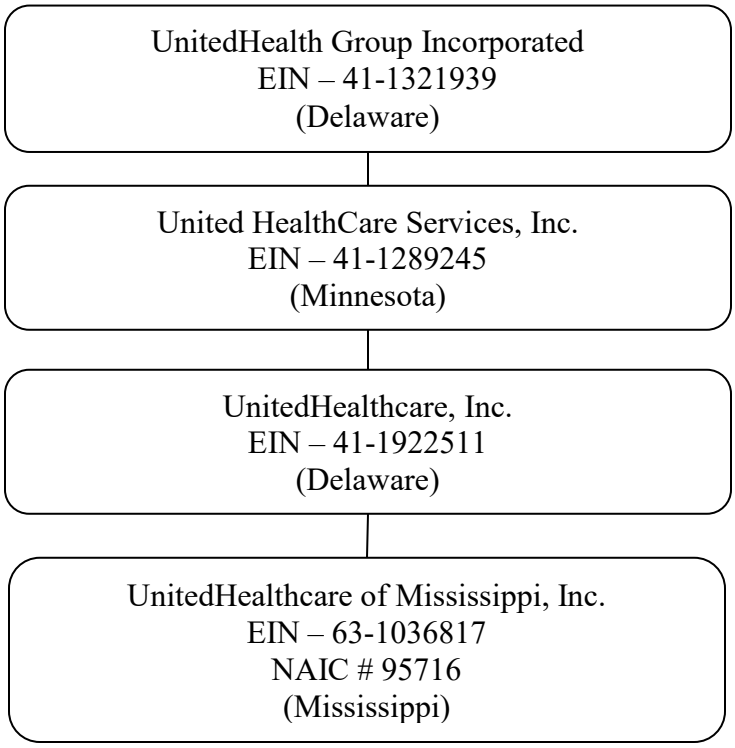
Conflict of Interest

The Company has an established policy whereby each officer and director completes a conflict of interest questionnaire each year disclosing any potential or conceivable conflict with the director's or officer's responsibilities within or for the Company. The conflict of interest questionnaires were completed by all the directors and officers of the Company for each year of the examination period. A review of the disclosures made by the officers and directors did not reveal any material exceptions to the Company's established policies.

HOLDING COMPANY STRUCTURE

Organizational Chart

The Company is a member of an insurance holding company system as defined in Miss. Code Ann. § 83-6-1. For the period covered by the examination, UHCMS filed holding company registration statements with the Mississippi Insurance Department ("MID" or "Department") in compliance with Miss. Code Ann. § 83-6-5 and § 83-6-9.



Parent and Affiliated Companies

UHG (ultimate parent) is a publicly-held company listed on the New York Stock Exchange under the ticker symbol UNH. As of December 31, 2021, UHG's consolidated assets were approximately $212.2 billion with a net worth of approximately $75.0 billion. The corporation is a diversified health and well-being company that deploys core competencies in advanced, enabling technology, health care data, information and intelligence, and clinical care management and coordination to help meet the demands of the health system, through two distinct business platforms: health benefits operating under UnitedHealthcare and health services operating under Optum. There are four reportable segments across the two business platforms, which include: UnitedHealthcare (consists of UnitedHealthcare Employer & Individual ("E&I"), UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State ("C&S"), and UnitedHealthcare Global); OptumHealth; OptumInsight; and OptumRx.

UHS is a wholly-owned HMO management corporation that provides health benefit programs for individuals and families, employers, military service members, retirees and their families, and Medicare and Medicaid beneficiaries. It offers Medicare plans, Medicaid plans, medical plans, consumer driven health plans, dental plans, vision plans, disability plans, life insurance plans, critical illness plans, and accident insurance plans. Plans are sold through brokers, consultants, Medicare agents and brokers, and online portals. Programs are offered through direct contracts with physicians and care professionals, hospitals, and other care facilities. The corporation was founded in 1977 and is based in Minnetonka, Minnesota. UHS operates as a subsidiary of UHG and provides services to the Company under the terms of a management services agreement.

UHC is a wholly-owned corporation that provides healthcare planning and management services through its subsidiaries. The corporation was incorporated in 1998, and operates as a subsidiary of UHS.

Affiliated and Related Party Transactions

The Company's transactions with related parties were reviewed and the following items were considered notable for purposes of this report:

- **Management Services Agreement**
  Effective January 1, 2011, UHCMS entered into a Management Services Agreement with UHS. Under the terms of the agreement, UHS provides management and operational support to the Company through a number of services, including but not limited to, banking, financial reporting, human resources, IT systems, audit, legal, compliance, regulatory affairs, facilities, taxes, insurance, treasury and investments, actuarial and underwriting, benefit design and administration, call centers and support activities, claims adjudication and payment systems, cost containment, data clearinghouse and warehouse systems, data management, disease management, financial administration systems, marketing, advertising, sales, public relations, medical management, payment integrity, pharmacy benefits management, provider networks and relations, quality oversight, specialty benefit management systems, third party administration, and wellness management. This agreement supersedes and replaces the Amended and Restated Management Agreement effective December 31, 1999. The agreement was submitted to the MID for review on November 30, 2010, and was approved on December 21, 2010.

  Effective January 1, 2015, UHCMS entered into the First Amendment to the Management Services Agreement with UHS. The amendment reflects modifications in the Third Party Administrator, Medicare Provisions and Medicaid Provisions, and the addition of an Exchange Regulatory Appendix Provision to comply with regulatory requirements. The first amendment was submitted to the MID for review on November 7, 2014, and was approved on November 24, 2014.

  Effective March 1, 2017, UHCMS entered into the Second Amendment to the agreement. The primary purpose of the amendment is to implement an updated methodology for calculating management fees. Specifically, the updated language implements a current year true-up, which will yield more accurate results and ensure that adjustments apply in the current year. Additionally, Exhibit A has been updated to include a more complete list of services subject to the agreement. The amendment was filed with the MID on January 20, 2017, and was approved by the Department on January 25, 2017.

  Fees under the agreement totaled the following during the examination period:

Management Services	2021	2020	2019	2018	2017
Management Fees	$60,118,991	$53,040,480	$56,408,030	$57,951,664	$67,141,589

- **UnitedHealthcare Insurance Company – Premium Allocation Agreement**
  Effective January 1, 1998, UnitedHealthcare Insurance Company ("UHIC") and UHS entered into a Premium Allocation Agreement acting on behalf of its affiliates including but not limited to UHCMS. UHCMS was added to the agreement as a participant through signing a Participating Addendum effective January 1, 1998. Under the terms of the agreement, UHIC provides health insurance coverage, which is marketed and issued in conjunction with products covered for members enrolled with the various managed care organizations under contract with UHS, including members enrolled with UHCMS. UHIC receives a percentage of consideration received for the policies and the HMO products.

  Effective December 1, 2007, an amendment was added to comply with SSAP No. 96 on Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties to be effective for reporting periods ending December 31, 2007, and thereafter.

- **Optum Biometrics, Inc. – Facility Provider Agreement**
  Effective October 1, 2010, UHCMS entered into a Facility Participation Agreement with Optum Biometrics, Inc. Under the terms of the agreement, the Company's Commercial members are provided influenza and pneumococcal vaccination services. The fees charged are per vaccination given and are the same for all customers. The agreement was submitted to the MID for review on August 20, 2010, and was approved on September 9, 2010.

- **OptumInsight, Inc. f/k/a Ingenix, Inc. Services Agreement**
  Effective July 1, 2011, UHCMS entered into a Services Agreement with Ingenix, Inc. Under the terms of the agreement, the Company is provided with services involving the investigation, pursuit, and recovery of health care claim overpayments occurring due to fraudulent, abusive, or other inappropriate billing activity. The agreement was submitted to the MID for review on May 11, 2011, and was approved on July 12, 2011.

  Effective January 1, 2013, UHCMS entered into the First Amendment to the agreement, which modified the agreement to the OptumInsight Services Agreement and amended the address for all notices and official communication for OptumInsight, Inc. ("OptumInsight"). In addition, Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", and Exhibit A-3, "Subrogation Services", were amended by the pricing terms and the compensation for E&I Benefit Plans was amended for Claims Analytics and Recovery Services. The amendment was submitted to the MID for review on November 12, 2012, and was approved on December 18, 2012.

  Effective September 1, 2013, UHCMS entered into the Second Amendment to the agreement, which amended certain compensation sections in Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", and Exhibit A-3, "Subrogation Services", amended the description of "Legal Action" in Exhibits A-1 and A-2, and deleted 2(d) and 2(e) from Exhibit A-3. The amendment was submitted to the MID for review on July 24, 2013, and was approved on August 15, 2013.

Effective May 1, 2014, UHCMS entered into the Third Amendment to the agreement, which amended certain compensation sections in Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", and Exhibit A-3, "Subrogation Services", and added Exhibit A-4, "Premium Audit Services." The amendment was submitted to the MID for review on March 24, 2014, and was approved on April 7, 2014.

Effective December 31, 2014, UHCMS entered into the Fourth Amendment to the agreement, which deleted and replaced Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", Exhibit A-3, "Subrogation Services", and Exhibit A-4, "Premium Audit Services", and added Exhibit E, "Exchange Regulatory Appendix." The amendment was submitted to the MID for review on November 7, 2014, and was approved on November 24, 2014.

Effective October 1, 2015, UHCMS entered into the Fifth Amendment to the agreement, which deleted and replaced Exhibit A-1, "Claim Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", Exhibit A-3, "Subrogation Services", and Exhibit A-4, "Premium Audit Services", deleted and replaced Exhibit C, "Mississippi Medicaid Program Regulatory Requirements Appendix", and added Exhibit C-1, "Mississippi Children's Health Insurance Program ("CHIP") Regulatory Requirements Appendix." The amendment was submitted to the MID for review on August 27, 2015, and was approved on September 15, 2015. approved

Between June 2017 and November 2019 UHCMS entered the Sixth, Seventh and Eighth Amendments to the agreement whereby Exhibits A-1, A-2, A-3 and A-4 were deleted and replaced. The amendments were filed with and approved by the MID.

Effective March 1, 2021, UHCMS entered into the Ninth Amendment to the agreement. The amendment deleted and replaced Exhibit A-1, "Claims Analytics and Recovery Services", Exhibit A-2, "Retrospective Fraud, Waste & Abuse Services", Exhibit A-3, "Subrogation Services", Exhibit A-4, "Premium Audit Services", and Exhibit C, "State Regulatory Requirements Appendix." The amendment was filed with the MID for review and approval on January 12, 2021, and was approved by on February 11, 2021.

Fees under the agreement totaled the following during the examination period:

OptumInsight Services	2021	2020	2019	2018	2017
Service Fees	$2,304,258	$3,850,943	$1,721,822	$1,857,676	$1,479,355

- **Spectera, Inc. Vision Services Agreement**
  Effective January 1, 2012, UHCMS entered into a Vision Services Agreement with Spectera, Inc. ("Spectera"). Under the terms of the agreement, Spectera is responsible for developing, contracting, and managing a network of Vision Providers to provide Vision Services and/or products for the Company's Commercial members. The agreement was

submitted to the MID for review on November 28, 2011, and was approved on December 22, 2011.

Effective January 1, 2014, UHCMS entered into the First Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum." The amendment was submitted to the MID for review on October 29, 2013, and was approved on November 7, 2013.

Effective April 1, 2014, UHCMS entered into the Second Amendment to the agreement, which added Specialty Benefits, LLC ("Specialty Benefits") as a party to the agreement. Specialty Benefits provides optometric materials, such as eyeglasses and contact lenses prescribed by network providers for the Company's members. The amendment also deleted and replaced Exhibit A, "Compensation for Services Addendum", and Exhibit B, "Services Addendum." The amendment was submitted to the MID for review on February 24, 2014, and was approved on March 5, 2014.

Effective January 1, 2015, UHCMS entered into the Third Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", and added Exhibit G, "Exchange Regulatory Appendix." The amendment was submitted to the MID for review on October 15, 2014, and was approved on November 5, 2014.

Effective January 1, 2016, UHCMS entered into the Fourth Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", and Exhibit F, "Delegated Credentialing Addendum", and added Exhibit H, "Third Party Administrator Appendix." The amendment was submitted to the MID for review on November 30, 2015, and was approved on December 16, 2015.

Between February 2017 and July 2020 UHCMS entered into the Fifth, Sixth and Seventh Amendments to the agreement whereby Exhibit A, "Compensation for Services Addendum" were deleted and replaced. The amendments were submitted to and approved by the MID.

Effective November 1, 2021, UHCMS entered into the Eighth Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum" and added Exhibit C, "Medicare Advantage Regulatory Requirements Appendix." The amendment was submitted to the MID for review and approval on September 21, 2021, and was approved on October 13, 2021.

Fees under the agreement totaled the following during the examination period:

Vision Services	2021	2020	2019	2018	2017
Vision Fees	$48,070	$2,995	$739,621	$2,034,217	$16,192,414

- **Dental Benefit Providers, Inc. – Dental Services Agreement**
  Effective February 1, 2012, UHCMS entered into a Dental Services Agreement with Dental

Benefit Providers, Inc. ("DBP"). Under the terms of the agreement, DBP is responsible for developing, contracting and managing a network of Dental Providers to provide dental services to the Company's Mississippi Coordinated Access Network ("Mississippi CAN") members. UHCMS remains ultimately responsible for the delivery of dental services to its members. The agreement was submitted to the MID for review on December 28, 2011, and was approved on January 23, 2012.

Effective November 1, 2013, UHCMS entered into the First Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum." The amendment was submitted to the MID for review on September 9, 2013, and was approved on September 30, 2013.

Effective January 1, 2014, UHCMS entered into the Second Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit C, "Medicare Advantage Regulatory Requirements Appendix", and Exhibit E, "State Regulatory Requirements Appendix." The amendment was submitted to the MID for review on November 14, 2013, and was approved on November 26, 2013.

Effective January 1, 2015, UHCMS entered into the Third Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum" and Exhibit E, "State Regulatory Requirements Appendix" and added Exhibit G, "Exchange Regulatory Appendix." The amendment was submitted to the MID for review on October 8, 2014, and was approved on October 23, 2014.

Effective July 1, 2015, UHCMS entered into the Fourth Amendment to the agreement, which added a rate for the Mississippi CHIP to Exhibit A, "Compensation for Services Addendum", added Exhibit E-1, "Mississippi CHIP Regulatory Requirements Appendix" and deleted and replaced Exhibit G, "Exchange Regulatory Appendix." The amendment was submitted to the MID for review on June 1, 2015, and was approved on June 15, 2015.

Effective May 1, 2017, UHCMS entered into the Fifth Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum" deleted and replaced Exhibit F, "Delegated Credentialing Addendum" and adds the "Third Party Administrator Appendix" as Exhibit H. The amendment was submitted to the MID for review and approval on May 15, 2017, and was approved on May 16, 2017.

Effective July 1, 2018, UHCMS entered into the Sixth Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit E "Mississippi CHIP Regulatory Requirements Appendix" and Exhibit E "Mississippi Medicaid Program Regulatory Requirements Appendix." The amendment was submitted to the MID for review and approval on May 30, 2018, and was approved on June 11, 2018.

Effective August 1, 2019, UHCMS entered into the Seventh Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum" and Exhibit C, "Medicare Advantage Regulatory Requirements Appendix." The

amendment was submitted to the MID for review and approval on June 10, 2019, and was approved on June 24, 2019.

Effective November 1, 2021, UHCMS entered into the Eighth Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit C, "Medicare Advantage Regulatory Requirements Appendix" and Exhibit E "Mississippi Medicaid Program Regulatory Requirements Appendix." The amendment was submitted to the MID for review and approval on September 21, 2021, and was approved on October 13, 2021.

Fees under the agreement totaled the following during the examination period:

Dental Services	2021	2020	2019	2018	2017
Dental Fees	$6,305,086	$6,292,463	$5,900,939	$4,506,096	$2,617,196

- **United Behavioral Health – Behavioral Health Services Agreement**
  Effective April 1, 2012, UHCMS entered into a Behavioral Health Services Agreement with United Behavioral Health ("UBH"). Under the terms of the agreement, UBH is responsible for arranging for the provision of certain mental health and substance abuse treatment services to the Company's members. This agreement supersedes and replaces the agreement for Provision of Services effective January 1, 1995, and all subsequent amendments. The agreement was submitted to the MID for review on February 23, 2012, and was approved on April 16, 2012.

  Effective March 1, 2013, UHCMS entered into the First Amendment to the agreement, which deleted and replaced the rate chart in its entirety in Section 1 of Exhibit A, "Compensation for Services Addendum." Additionally, the amendment reflects the associated third-party administrative services and the Reinsurance Agreement between UHCMS and Unimerica Insurance Company ("Unimerica") that provides for the assumption of risk for a limited portion of benefits provided by the Company on a reinsurance basis. The amendment was submitted to the MID for review on January 28, 2013, and was approved on February 20, 2013.

  Effective November 1, 2013, UHCMS entered into the Second Amendment to the agreement, which deleted and replaced the rate chart in its entirety in Section 1 of Exhibit A, "Compensation for Services Addendum", and added rates for the Mississippi Medicaid Program. The amendment was submitted to the MID for review on September 18, 2013, and was approved on September 25, 2013.

  Effective February 1, 2014, UHCMS entered into the Third Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum." The amendment was submitted to the MID for review on December 30, 2013, and was approved on January 21, 2014.

  Effective August 1, 2015, UHCMS entered into the Fourth Amendment to the agreement,

which deleted and replaced Exhibit A, "Compensation for Services Addendum", and Exhibit E, "Mississippi Medicaid Program Regulatory Requirements Appendix", and added Exhibit E-1, "Mississippi CHIP Regulatory Requirements Appendix", and Exhibit G, "Exchange Regulatory Appendix." The amendment was submitted to the MID for review on June 30, 2015, and was approved on July 22, 2015.

Effective September 1, 2016, UHCMS entered into the Fifth Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit E, "Mississippi Medicaid Program Regulatory Requirements Appendix", and Exhibit F, "Delegated Credentialing Addendum", and added Exhibit H, "Third Party Administrator Appendix." The amendment was submitted to the MID for review on July 25, 2016, and was approved on August 18, 2016.

Effective September 1, 2017, UHCMS entered into the Sixth Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum." The amendment was submitted to the MID for review and approval on July 17, 2017, and was approved on August 9, 2017.

Effective February 1, 2019, UHCMS entered into the Seventh Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum", and deleted and replaced Exhibit E, Mississippi Medicaid Regulatory Requirements Appendix and Exhibit E, Mississippi CHIP Regulatory Requirements Appendix. The amendment was submitted to the MID for review and approval on December 20, 2018, and was approved on January 10, 2019.

Between September 2019 and September 2021 UHCMS entered into the Eighth, Ninth and Tenth Amendments to the agreement whereby the Exhibit A "Compensation for Services Addendum" were deleted and replaced. The amendments were submitted and approved by the MID.

Fees under the agreement totaled the following during the examination period:

Behavioral Health Services	2021	2020	2019	2018	2017
Behavioral Health Fees	$9,088,376	$10,950,597	$10,160,225	$8,418,931	$10,214,005

- **OptumRx, Inc. – Prescription Drug Benefit Administration Agreement for Commercial Members**
  Effective January 1, 2013, OptumRx and UHS entered into a Prescription Drug Benefit Administration Agreement. UHCMS was added to the agreement as a participant through signing a Participating Addendum effective January 1, 2013. The agreement covers the Company's commercial members only. Under the terms of the agreement, OptumRx is providing UHCMS with Core Prescription Drug Benefit Services and Mail Order Pharmacy Services. Under the Core Prescription Drug Benefit Services, OptumRx established and maintain a network of pharmacies to service the benefit plans, provide

claims processing services, benefits administration and support, marketing and sales support, account management services, rebate administration, clinical services and finance and analytical support services. Under the Mail Order Pharmacy Services, OptumRx provides the Company with mail order network prescription services. UHCMS remains ultimately responsible for the pharmacy benefit administration services provided to its members. The agreement was submitted to the MID for review on September 21, 2012, and was approved on October 5, 2012.

Effective September 1, 2015, UHCMS entered into a Participating Plan Addendum to participate in the First and Second Amendments to the agreement. The First amendment added Exhibit D, "Exchange Regulatory Appendix" and Exhibit E, "Third Party Administrator and Other Services," and the Second amendment updated rates and other definitions. The agreement continues to cover the Company's commercial members only. The amendments were submitted to the MID for review on July 30, 2015, and were approved on August 17, 2015.

Effective August 1, 2020, UHCMS entered into a Participating Plan Addendum to participate in the Fourth Amendment to the agreement. The amendment deleted and replaced Exhibit B. Specifically, the amendment added UnitedHealthcare of South Carolina, Inc. to Exhibit B of the agreement, "United Affiliates." In addition, UnitedHealthcare Community Plan, Inc. and UnitedHealthcare of Pennsylvania, Inc. were added back to the affiliates listing. The MID notified UHCMS on May 7, 2020, that a Form D would not be necessary for this change.

Effective January 1, 2021, UHCMS entered into a Participating Plan Addendum to participate in the Fifth Amendment to the agreement. Specifically, the amendment amended the pricing in Exhibit B-1(a) to include work to be performed by OptumRx for individual exchange business and is also amended the pricing for clinical coverage reviews. Rocky Mountain Health Plan has been added for certain individual exchange business under the agreement. The amendment was filed for review and approval with the MID on October 26, 2020, and was approved on November 17, 2020.

Effective October 1, 2021, UHCMS entered into a Participating Plan Addendum to participate in the Sixth Amendment to the agreement. The amendment deleted and replaced Exhibit B. Specifically, the amendment added Tufts Health Freedom Insurance Company to Exhibit B of the agreement, "United Affiliates." The MID previously notified UHCMS that a Form D would not be necessary for this change.

- **OptumHealth Care Solutions, Inc. – Administrative Services Agreement**
  Effective March 1, 2013, UHCMS entered into an Administrative Services Agreement with OptumHealth Care Solutions, LLC ("OptumHealth"). Under the terms of the agreement, OptumHealth is responsible for managing a network of therapy providers and other administrative functions in order to provide physical health solutions such as chiropractic and physical, occupation and speech therapy for the Company's Commercial and Medicaid members. UHCMS remains ultimately responsible for the delivery of therapy services to its members. The agreement was submitted to the MID for review on January 28, 2013,

and was approved on February 20, 2013.

Effective January 1, 2015, UHCMS entered into the First Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit C, "Medicare Advantage Regulatory Requirements Appendix", and Exhibit E, "Mississippi Medicaid Regulatory Requirements Appendix", and added Exhibit G, "Exchange Regulatory Appendix." The amendment was submitted to the MID for review on November 17, 2014, and was approved on December 2, 2014.

Effective September 1, 2016, UHCMS entered into the Second Amendment to the agreement, which deleted and replaced Exhibit A, "Compensation for Services Addendum", Exhibit E, "Mississippi Medicaid Program Regulatory Requirements Appendix", and Exhibit F, "Delegated Credentialing Addendum", and added Exhibit E-1, "Mississippi CHIP Regulatory Requirements Appendix" and Exhibit H, "Third Party Administrator Appendix." The amendment was submitted to the MID for review on July 25, 2016, and was approved on August 18, 2016.

Effective December 1, 2019, UHCMS entered into the Third Amendment to the agreement. The amendment deleted and replaced Exhibit A, "Compensation for Services Addendum" and Exhibit E, "Medicaid State Regulatory Requirements Appendix." The amendment was submitted to the MID for review and approval on December 24, 2019, and was approved on January 14, 2020.

Fees under the agreement totaled the following during the examination period:

OptumHealth Services	2021	2020	2019	2018	2017
Service Fees	$334,654	$331,962	$287,591	$334,255	$373,634

- **OptumRx, Inc. – Facility Participation Agreement – Specialty Pharmacy for the Medical Benefit**

  Effective December 1, 2015, UHCMS entered into a Facility Participation Agreement with OptumRx. Under the terms of the agreement, OptumRx is acting as a specialty pharmacy provider. OptumRx provides the specialty pharmacy medications covered under the member's medical benefits. In addition to dispensing and delivering the specialty pharmacy medications, OptumRx is providing information, including side effect management, storage of the medication, missed dose management, and disease state information, to the Company's members or their caregivers. OptumRx is also providing access to customer service representatives and pharmacists to provide support and guidance to UHCMS's members and family members. The agreement was submitted to the MID for review on October 28, 2015, and was approved on November 17, 2015.

  Effective July 1, 2018, UHCMS entered into the First Amendment to the agreement. The amendment deleted and replaced Appendix 4, "State Regulatory Requirements Appendix" and deleted and replaced Appendix 3 "Specialty Pharmacy Services and Compensation" with Appendix 3 "Payment Appendix Specialty Pharmacy Services Year 1 Effective

7/1/2018 - 6/30/2019" and "Appendix 3 Payment Appendix Specialty Pharmacy Services Year 2 Effective 7/1/2019 - 7/20/2020." The amendment was filed with the Department on May 21, 2018, and was approved on June 11, 2018.

- **OptumRx, Inc. – Facility Participation Agreement – Specialty Pharmacy for the Pharmacy Benefit**
  Effective July 1, 2018, UHCMS entered into the Facility Participation Agreement. Pursuant to the agreement, OptumRx is acting as a specialty pharmacy provider. OptumRx provides the specialty pharmacy medications covered under the member's pharmacy benefits. In addition to dispensing and delivering the specialty pharmacy medications, OptumRx is providing information, including side effect management, storage of the medication, missed dose management, and disease state information, to UHCMS's members or their caregivers. OptumRx is also providing access to customer service representatives and pharmacists to provide support and guidance to UHCMS's members and family members. The agreement was submitted to the MID for review and approval on May 21, 2018, and was approved on June 11, 2018.

- **AxelaCare Intermediate Holdings, LLC – Facility Participation Agreement**
  Effective February 1, 2016, UHCMS entered into a Facility Participation Agreement with AxelaCare Intermediate Holdings, LLC ("AxelaCare"). Under the terms of the agreement, AxelaCare provides home infusion therapy services, including per diem nursing services and the cost of drugs. The agreement was submitted to the MID for review on December 30, 2015, and was approved on February 1, 2016.

  Effective January 1, 2019, UHCMS entered into the First Amendment to the agreement. The amendment deleted and replaced Exhibit 3, "Home Infusion Therapy Payment Appendix", Exhibit 3A "Supplemental Medicaid Payment Appendix", Appendix 4, "Mississippi Regulatory Requirements Appendix" and Appendix 5, the "Mississippi Medicaid Regulatory Requirements Appendix." The amendment was filed with the MID on November 19, 2018, and was approved on December 5, 2018.

- **OptumRx, Inc. – Third Amended and Restated Prescription Drug Benefit Administration Agreement**
  Effective November 1, 2016, OptumRx and UHS entered into a Third Amended and Restated Prescription Drug Benefit Administration Agreement acting on behalf of its affiliates, including but not limited to UHCMS. Under the terms of the agreement, OptumRx is responsible for establishing and maintaining a network of participating pharmacies, prescription drug claims processing services, and general administrative support as to the prescription drug benefit covered for members enrolled with the various managed care organizations under contract with UHS, including members enrolled with UHCMS. The agreement applies to the Company's Medicaid members. UHCMS remains ultimately responsible for assuring coverage of all prescription drug benefit services to its members. This Agreement replaces the Amended and Restated Prescription Drug Benefit Administration Agreement, effective January 1, 2010, and the Second Amended and Restated Prescription Drug Benefit Administration Agreement, effective January 1, 2013, and all subsequent amendments. The agreement was submitted to the MID for review on

September 28, 2016, and was approved on October 31, 2016.

Between January 2017 and January 2018 OptumRx entered into the First and Second Amendments with affiliated Health Maintenance Organizations and entities that only impacted members that reside in other states and did not impact UHCMS's members. This information is only provided to explain the numbering of amendments.

Effective July 1, 2018, UHS and OptumRx entered into the Third Amendment to the agreement. The amendment updated pricing by deleting and replacing Exhibit C-1 for Mississippi CHIP and Exhibit C-3 for Mississippi CAN Medicaid. The agreement also updated Exhibit 11, "Mississippi Regulatory Requirements." UHCMS began participating in the amendment by signing a Participating Addendum effective July 1, 2018. The amendment and Participating Addendum were filed with the MID for review and approval on May 30, 2019, and were approved on June 11, 2018.

Between January 2019 and March 2019 OptumRx entered into the Fourth, Fifth, Sixth and Seventh Amendments with affiliated Health Maintenance Organizations and entities that impacted members that reside in other states and did not impact UHCMS's members. This information is only provided to explain the numbering of amendments.

Effective August 1, 2019, Optum Rx and UHS entered into the Eighth Amendment to the agreement. The amendment deleted and replaced Exhibit B, Exhibit C-3. UHCMS began participating in the amendment by signing a Participating Addendum effective August 1, 2019. The amendment and Participating Addendum were filed with the MID for review and approval on June 10, 2019, and were approved on June 24, 2019.

In October 2019 OptumRx entered into the Ninth Amendment with affiliated Health Maintenance Organizations and entities that only impacted members that reside in other states and did not impact UHCMS's members. This information is only provided to explain the numbering of amendments.

Effective November 1, 2019, OptumRx and UHS entered into the Tenth Amendment to the agreement. The amendment deleted and replaced the "MAC List's" in Exhibit A and Exhibit B. UHCMS began participating in the amendment by signing a Participating Addendum effective November 1, 2019. The amendment and Participating Addendum were filed with the MID for review and approval on September 26, 2019, and were approved on October 25, 2019.

Between December 2019 and January 2020 OptumRx entered into the Eleventh and Twelfth Amendments with affiliated Health Maintenance Organizations and entities that only impacted members in other states and did not impact UHCMS's members. This information is only provided to explain the numbering of amendments.

Effective February 1, 2020, OptumRx and UHS entered into the Thirteenth Amendment to the agreement. The amendment deleted and replaced Section 1.6, Material Changes to Services, added Section 1.7, and deleted and replaced Exhibit C-3(a) and Exhibit C-3(b)

for Mississippi CHIP. UHCMS began participating in the amendment by signing a Participating Addendum effective February 1, 2020. The amendment and Participating Addendum were filed with the MID for review and approval on December 24, 2019, and were approved on January 14, 2020.

Effective September 1, 2020, OptumRx and UHS entered into the Fourteenth Amendment to the agreement. The amendment added Section 8.13 and Section 5.11 of Exhibit C. UHCMS began participating in the amendment by signing a Participating Addendum effective September 1, 2020. The amendment and Participating Addendum were filed with the MID for review and approval on July 29, 2020, and were approved on August 14, 2020.

Between January 2020 and December 2020 OptumRx entered into the Fifteenth, Sixteenth, Seventeenth, Eighteenth, Nineteenth and Twentieth Amendments with affiliated Health Maintenance Organizations and entities that only impacted members that reside in other states and did not impact UHCMS's members. This information is only provided to explain the numbering of amendments.

Effective January 1, 2021, UHS and OptumRx entered into the Twenty-First Amendment to the agreement. The amendment deleted and replaced Exhibit B, Exhibit C-8 Texas Medicaid, Exhibit E-17 for Texas Regulatory Appendix. UHCMS began participating in the amendment by signing a Participating Addendum effective January 1, 2021. The amendment and Participating Addendum were filed with the MID for review and approval on November 27, 2020, and were approved on December 14, 2020.

Between January 2021 and December 2021 OptumRx entered into the Twenty Second, Twenty Third, Twenty Fourth, Twenty Fifth, Twenty Sixth, Twenty Seventh and Twenty Eighth Amendments with affiliated Health Maintenance Organizations and entities that only impacted members that reside in other states and did not impact UHCMS's members. This information is only provided to explain the numbering of amendments.

Fees under the agreement totaled the following during the examination period:

Prescription Drug Benefit	2021	2020	2019	2018	2017
Administration Fees	$201,845,180	$187,700,489	$29,288,437	$20,093,939	$7,387,461

- **Combined Billing and Disbursement Operations Agreement**
  Effective June 9, 2004, UHCMS entered into a Combined Billing and Disbursement Operations Agreement with UHIC and UHS. Under the terms of the agreement, UHS has consolidated its computer platforms in order to bring greater efficiency in the delivery of products and services from its affiliates. Additionally, customers are provided a combined bill and a common bank lockbox held in the name of UHIC to direct single premium payments to. All incoming receipts are identified and sorted according to proper affiliate

company, and promptly transferred to the appropriate health plan or insurer owned account. The agreement does not provide for pooling of assets for investment or investment-related purposes. The agreement was submitted to the MID for review on March 18, 2004, and was approved on June 9, 2004. Premium income subject to the agreement totaled the following during the examination period:

Premiums	2021	2020	2019	2018	2017
Net Premium Income	$1,091,436,462	$1,083,761,007	$993,404,401	$1,144,574,860	$1,104,347,709

- **Amended and Restated Subordinated Revolving Credit Agreement**
  Effective October 1, 2012, UHCMS entered into the Amended and Restated Revolving Credit Agreement with UHG. Under the terms of the agreement, UHG is providing a short-term borrowing facility for UHCMS which shall be repaid within one year of the date on which the loan was initially made. UHCMS is able to borrow upon demand from UHG up to a maximum amount of $15,000,000.00 outstanding at any time. The agreement was filed with the MID for review and approval on August 15, 2012, and was approved on October 5, 2012.

  Effective November 1, 2018, UHCMS entered into the First Amendment to the Amended and Restated Revolving Credit Agreement with UHG. The Amendment updated Exhibit A to increase the aggregate principal amount to $75,000,000. The amendment was filed with the MID for review and approval on September 24, 2018, and was approved on October 15, 2018.

- **Real Appeal, Inc. National Ancillary Provider Participation Agreement**
  Effective January 1, 2019, UHIC entered into a National Provider Participation Agreement with Real Appeal, Inc. ("Real Appeal"). Pursuant to the agreement, Real Appeal will provide Obesity and Diabetes Prevention Services focusing on weight loss to commercial members for UHIC and its affiliates. The services include a customizable program delivered to eligible participants with a goal of preventing diabetes and other obesity related diseases. The program uses a 52-week approach with online technology and live audio/video capabilities. UHCMS signed a participating addendum effective January 1, 2019 to participate in the agreement. The effective dates of the agreement and Participating Addendum were changed from August 1, 2018 to January 1, 2019, due to the timing of approval of the agreement from the Connecticut Department of Insurance where UHIC is domiciled. The agreement was submitted to the MID on June 22, 2018, and was approved on July 11, 2018.

  Effective January 1, 2020, UHIC and Real Appeal entered into a First Amendment to the agreement. The amendment deleted and replaced the January 1, 2020, Weight Loss Program Payment Appendix – All Payer. UHCMS signed a Participating Addendum effective January 1, 2020 to participate in the agreement. The agreement and subsequent amendment are a Fee for Services arrangement.

- **OptumRx, Inc. – First Amended and Restated Medicare Prescription Drug Benefit Administration Agreement (MA-PD PLANS AND PDP PLANS)**
  Effective January 1, 2018, OptumRx, Inc. ("OptumRx") and UnitedHealthcare Services, Inc. entered into the First Amended and Restated Medicare Prescription Drug Benefit Administration Agreement, acting on behalf of its affiliates listed in the Exhibit B of agreement. Under the terms of the agreement, OptumRx is the Pharmacy Benefit Manager for Registrant's Individual MA-PD Plans and PDP Plans.

  Effective August 1, 2018, OptumRx and UHS entered into the First Amendment to the agreement. The amendment updated Section 3.8 of Exhibit C to reflect the inclusion of real time audits and fax audits in the desk top audit recovery work performed by Administrator and amended Exhibit C-1 to clarify the amount of the Network Pharmacy Audit Recovery Incentive payment for real-time audits.

  Effective January 1, 2019, OptumRx and UHS entered into the Second Amendment to the agreement. The amendment updated various sections of the agreement including Exhibit C-1, Exhibit F, Exhibit H and the amendment to the Mail Order Agreement.

  Effective March 1, 2020, OptumRx and UHS entered into the Third Amendment to the agreement. The amendment updated various sections of the agreement, 1.3 Services, 3.7 Maximum Allowable Cost List, Exhibit A, Exhibit B, Exhibit C, Exhibit C1, Exhibit E, Exhibit F and Exhibit B-1 to the amendment to the Mail Order Agreement.

  Effective January 1, 2021, OptumRx and UHS entered into the Fourth Amendment to the agreement. The amendment updated various sections of the agreement and the amendment to the Mail Order Agreement.

  Effective January 1, 2021, UHCMS is participating in the agreement and subsequent amendment by signing a Participating Addendum effective January 1, 2021. The agreement, subsequent amendments and the Participating Addendum were filed with the MID for review and approval on November 5, 2020, and were approved on November 23, 2020.

- **Optum Women's and Children's Health, LLC f/k/a Alere Women's and Children's Health LLC – National Ancillary Provider Participation Agreement**
  Effective November 1, 2017, UHIC entered into the National Ancillary Provider Participation Agreement on behalf of itself and other affiliates with Optum Women's and Children's Health, LLC ("OWCH"). UHCMS participates in the agreement by entering into a Participating Addendum effective November 1, 2017. The effective dates of the agreement and participating addendum were changed from September 1, 2017 to November 1, 2017 due to the timing of approval of the agreement from the Connecticut Department of Insurance where UHIC is domiciled. Under the terms of the agreement, OWCH provides home infusion therapy to commercial, and Medicaid pregnant women in need of certain hormonal and insulin therapy. The services provided include all pharmacy and clinical management/coordination, all infusion related supplies and equipment inclusive of IV poles and pumps (stationary, ambulatory, and disposable), delivery and

associated mileage, hazardous waste disposal, patient education materials, medications, nursing services, diluents and solutions inclusive of flushes. The agreement was submitted to the MID on July 31, 2017, and was approved by on August 10, 2017.

- **National MedTrans, LLC Administrative Services Agreement**
  Effective September 1, 2018, UHCMS entered into an Administrative Services Agreement with National MedTrans, LLC ("MedTrans"). Pursuant to the agreement, MedTrans administers non-emergency medical transportation ("NEMT") services through its relationships with contracted and non-contracted transportation providers that are available to provide NEMT services to UHMS Members. The agreement was submitted to the MID for review and approval on July 31, 2018, and was approved on August 27, 2018.

- **March Vision Care Group, Incorporated – Vision Services Agreement**
  Effective December 1, 2019, UHCMS entered into the Third Amendment to Vision Services Agreement with March Vision Care Group, Incorporation ("March Vision"). The Vision Services Agreement effective January 1, 2017, the First Amendment also effective January 1, 2017 and the Second Amendment effective February 1, 2018 were not previously provided to the MID and were enclosed with the approval filing of the Third Amendment. Pursuant to the agreement, March Vision is responsible for claims processing and other administrative function related to its vision services, as well as managing a network of vision providers to provide vision services to UHCMS's dual Medicare/Medicaid and Medicaid members. UHCMS remains ultimately responsible for the delivery of vision health care to its members. The agreement, the first, second and third amendments to the agreement were submitted to the MID for review and approval on October 15, 2019, and were approved on November 1, 2019.

- **Amended and Restated Tax Sharing Agreement**
  UHCMS entered into an Amended and Restated Tax Sharing Agreement effective March 1, 2019 with UHG. The agreement is a restatement of the Tax Sharing Agreement effective January 1, 1996. The agreement establishes a formal method for the allocation and payment of federal, state and local income tax liabilities related to the consolidated federal tax returns of UHG and its subsidiaries filed each year. The agreement was submitted to the MID for review and approval on December 10, 2018, and was approved on December 27, 2018.

  Taxes under the agreement totaled the following during the examination period:

Taxes	2021	2020	2019	2018	2017
Federal & Foreign Income Taxes Incurred	$10,792,225	$18,755,048	$5,980,846	$6,945,808	$(1,476,195)

- **Unimerica Insurance Company – Reinsurance Agreement**
  Effective March 1, 2013, UHCMS entered into the Reinsurance Agreement with Unimerica Insurance Company effective December 31, 2017, the agreement and all subsequent amendments were terminated.

Due to prior period adjustments for the agreement, for periods when the agreement was active, the net income incurred under the agreement is $10,896.

- **Cash Contribution from Parent**
  The Company received one cash contribution of $65,000,000 from UHC during the examination period as an increase to gross paid-in and contributed surplus.

FIDELITY BOND AND OTHER INSURANCE

Pursuant to Miss. Code Ann. § 83-41-311(2), a HMO shall maintain in force a fidelity bond or fidelity insurance on employees and officers, directors and partners in an amount not less than $250,000 for each HMO or a maximum of $5,000,000 in aggregate maintained on behalf of HMOs owned by a common parent corporation, or such sum as may be prescribed by the commissioner. The Company is a named insured on UHG's Blanket Crime Policy with a coverage limit of $25,000,000 issued by an authorized company. The amount of coverage exceeds the minimum requirements in accordance with Miss. Code Ann. § 83-41-311(2). The Company is also a named insured on policies issued by authorized companies for normal hazards incident to conducting ordinary business.

PENSIONS, STOCK OWNERSHIP AND INSURANCE PLANS

The Company has no employees. All personnel are employees of UHS, pursuant to the management services agreement. Therefore, UHCMS does not provide any defined benefit or contribution plans, multiemployer plans, or postretirement plans.

TERRITORY AND PLAN OF OPERATION

The Company is licensed as a HMO to offer a variety of managed care programs and products to its enrollees in all Mississippi counties, consisting primarily of employer groups and Medicaid eligible beneficiaries. UHCMS operates under two of UHG's functional lines: Medicaid (C&S) and Commercial Products (E&I). C&S products made up approximately 91% of the Company's 2021 written premium, provided to high-risk Medicaid beneficiaries through the Mississippi CAN and eligible beneficiaries through CHIP. These health care services were provided under the Company's contracts with the Mississippi Division of Medicaid. E&I products made up approximately 9% of the Company's 2021 written premium, primarily consisting of group comprehensive hospital & medical plans for employers and individuals.

In 2015, the Company began participating in Individual Exchange in the State of Mississippi and effective January 1, 2017, the Company exited the Individual Exchange business. Effective January 1, 2021, the Company served as a plan sponsor offering Medicare Parts A and B, along with Medicare Part D prescription drug insurance coverage under contracts with CMS. Effective

January 1, 2022, the Company novated its Medicare contract with CMS to an affiliate, UnitedHealhtcare of Wisconsin, Inc.

GROWTH OF COMPANY

The following table indicates key figures in evaluating the growth of the Company during the examination period:

	2021	2020	2019	2018	2017
Total admitted assets	$ 322,963,213	$ 336,323,956	$ 255,816,526	$ 277,013,930	$ 286,589,813
Total liabilities	188,043,186	147,146,398	87,090,235	112,262,205	145,957,448
Total capital and surplus	134,920,027	189,177,558	168,726,291	164,751,725	140,632,365
Direct premiums written	1,091,436,462	1,083,761,007	993,404,401	1,144,487,491	1,169,367,968
Ceded premiums written	-	-	-	(87,369)	65,020,259
Net premium income	1,091,436,462	1,083,761,007	993,404,401	1,144,574,860	1,104,347,709
Net underwriting gain (loss)	47,870,820	68,634,556	22,048,334	35,365,748	(32,622,019)
Net income or (loss)	41,018,137	53,800,701	21,477,842	32,626,842	(30,183,267)

RESERVING AND UNPAID CLAIMS EXPERIENCE

The Company's opining actuary, Mr. Gary Iannone, ASA, MAAA, issued the actuarial opinion for the examination period. The actuarial opinions reported that the amounts carried in the balance sheets for reserves and related actuarial items were fairly stated and computed in accordance with reserving standards and actuarial principles, reasonably provided for all unpaid claims and claims adjustment expense obligations of the Company, and met the requirements of the insurance laws of the State of Mississippi.

The Company's unpaid claims and claims adjustment expense reserves were reviewed as part of the current examination. Per the review, no adjustments were required to the Company's unpaid claims and claims adjustment expense reserves, as of December 31, 2021.

REINSURANCE

During 2017, the Company ceded 100% of covered obligations to Unimerica relating to specialty health coverages, including mental health and substance abuse treatments and services and chiropractic and physical therapy treatments and services. In consideration of the reinsurance provided, UHCMS paid a reinsurance premium to Unimerica. Reinsurance premiums ceded, calculated on a PMPM basis, of $65,020,259 as of December 31, 2017, were netted against net premium income. Unimerica reimbursed the Company for the ceded percentage of claims incurred in connection with the covered obligations, in addition to an expense allowance to compensate UHCMS for administrative services provided. As of December 31, 2017, reinsurance recoveries totaled $63,051,971, and amounts recoverable from reinsurers totaled $5,089,831. This agreement was terminated effective December 31, 2017.

The Company did not assume any reinsurance during the examination period.

ACCOUNTS AND RECORDS

The Company's books and records are fully automated. The Company, as a member of a holding company group, utilizes common systems for recording its transactions. The group's current general ledger system is a purchased package (Oracle PeopleSoft), which maintains GAAP, Statutory, and MLR data. The Company uses Eagle Wings filing software to produce its statutory Annual Statement. Tests of the Company's accounts and records were determined based upon the examination procedures promulgated by the NAIC and applicable policies and directives issued by the Department. The Company's systems appear to furnish a reliable audit trail.

The Company's financial statements are subject to an annual audit conducted by independent certified public accountants. Deloitte & Touche, LLP performed the statutory audit for all years in the examination period. Unqualified opinions were issued for each year of the examination period.

STATUTORY DEPOSITS

The Company's statutory deposit with the State of Mississippi complied with Miss. Code Ann. § 83-41-325. The following chart displays the Company's deposit as of December 31, 2021:

Description	Par Value	Book Value	Fair Value
US Treasury Note	$520,000	$530,500	$529,027

FINANCIAL STATEMENTS

Introduction

The following financial statements reflect the same amounts reported by the Company and consist of a Statement of Assets, Liabilities, Capital and Surplus – Statutory at December 31, 2021, a Statement of Revenue and Expenses – Statutory for the year ended December 31, 2021, a Reconciliation of Capital and Surplus – Statutory for examination period ended December 31, 2021, and a Reconciliation of Examination Adjustments to Surplus – Statutory at December 31, 2021.

STATEMENT OF ASSETS, LIABILITIES, CAPITAL AND SURPLUS
DECEMBER 31, 2021

ASSETS

Bonds	$ 153,886,244
Cash, cash equivalents and short-term investments	140,803,359
Receivables for securities	283
Cash and invested assets	294,689,886
Investment income due and accrued	768,174
Uncollected premiums and agents' balances in the course of collection	3,847,408
Accrued retrospective premiums and contracts subject to redetermination	10,216,704
Amounts receivable relating to uninsured plans	5,681,323
Current federal and foreign income tax recoverable and interest thereon	2,608,954
Net deferred tax asset	424,819
Health care and other amounts receivable	3,466,006
Aggregate write-ins for other than invested assets	1,259,939
Total Assets	**$ 322,963,213**

LIABILITIES, CAPITAL AND SURPLUS

Claims Unpaid	$ 69,918,153
Accrued medical inventive pool and bonus amounts	1,970,475
Unpaid claims adjustment expenses	675,445
Aggregate health policy reserves	102,323,192
Aggregate health claim reserves	1,112,534
Premiums received in advance	95,238
General expenses due or accrued	1,406,797
Amounts withheld or retained for the account of others	207
Remittances and items not allocated	195
Amounts due to parent, subsidiaries and affiliates	1,163,416
Liability for amounts held under uninsured plans	3,643,087
Aggregate write-ins for other liabilities	5,734,447
Total Liabilities	**188,043,186**
Common capital stock	20
Gross paid in and contributed surplus	119,827,293
Unassigned funds (surplus)	15,092,714
Total Capital and Surplus	**134,920,027**
Total Liabilities, Capital and Surplus	**$ 322,963,213**

STATEMENT OF REVENUE AND EXPENSES
FOR YEAR ENDED DECEMBER 31, 2021

Member Months	2,585,526
Revenues	
Net premium income	$1,091,434,462
Change in unearned premium reserves and reserve for rate credits	(40,718,995)
Total revenues	$1,050,715,467
Expenses	
Hospital/medical benefits	$ 627,298,418
Other professional services	56,750,829
Prescription drugs	196,212,266
Incentive pool, withhold adjustments and bonus amounts	1,999,285
Net reinsurance recoveries	10,896
Total hospital and medical	882,271,694
Claims adjustment expenses, including cost containment expenses	47,586,398
General administrative expenses	72,988,555
Total underwriting deductions	1,002,846,647
Net underwriting gain or (loss)	47,870,820
Net investment income earned	3,769,480
Net realized capital gains (losses) less capital gains tax	194,945
Net investment gains (losses)	3,964,425
Net gain or (loss) from agents' or premium balances charged off	(24,883)
Net income after capital gains tax and before all other federal income taxes	51,810,362
Federal and foreign income taxes incurred	10,792,225
Net Income	$ 41,018,137

RECONCILIATION OF CAPITAL AND SURPLUS
FOR EXAMINATION PERIOD ENDED DECEMBER 31, 2021

	2021	2020	2019	2018	2017
Capital and surplus prior reporting year	$ 189,177,558	$ 168,726,291	$ 164,751,725	$ 140,632,365	$ 96,770,889
Net income or (loss)	41,018,137	53,800,701	21,477,842	32,626,842	(30,183,267)
Change in net unrealized capital gains (losses)	-	(382)	380	2	-
Change in net deferred income tax	(713,833)	223,252	(244,136)	(5,597,600)	3,157,141
Change in nonadmitted assets	3,438,165	(3,572,304)	2,740,480	(2,909,884)	5,887,602
Paid in	-	(25,500,000)	(20,000,000)	-	65,000,000
Dividends to stockholders	(98,000,000)	(4,500,000)	-	-	-
Net change in capital and surplus	(54,257,531)	20,451,267	3,974,566	24,119,360	43,861,476
Capital and surplus end of reporting period	$ 134,920,027	$ 189,177,558	$ 168,726,291	$ 164,751,725	$ 140,632,365

RECONCILIATION OF EXAMINATION ADJUSTMENTS TO SURPLUS
DECEMBER 31, 2021

There were no changes made to the assets, liabilities or capital and surplus reported by the Company for the year ended December 31, 2021. The Company's net worth, which totaled $134,920,027 as of the examination date, was determined to be reasonably stated and in compliance with Miss. Code Ann. § 83-41-325.

MARKET CONDUCT ACTIVITIES

A limited scope, Market Conduct examination was conducted in conjunction with the financial examination that included the following areas:

Privacy
Complaint Handling
Producer Licensing
Underwriting and Rating
Grievance Procedures
Network Adequacy
Provider Credentialing
Claims

The purpose of the limited scope Market Conduct examination was to review compliance by the Company with Mississippi Insurance Laws, Regulation, Bulletins and the NAIC Guidelines. NAIC Guidelines set the standard of conduct for a health insurer and promote a program of fair treatment of policyholders. Additionally, the examination reviewed certain areas as directed by the Chief Examiner of the MID.

A risk-focused approach was used to understand and assess the effectiveness of administrative and operating internal controls utilized by the Company to address selected market conduct requirements. Generally, examiners gained an understanding of controls and risk mitigation strategies and performed tests, as considered necessary, to assess the effectiveness of the controls and risk mitigation strategies.

Privacy

The Company's policies, practices and procedures regarding protection and disclosure of nonpublic personal information were reviewed to verify compliance with applicable state laws regarding privacy. The Company also has training processes in place to ensure privacy regulatory requirements are properly disseminated and understood throughout the organization. The Company appears to have appropriate procedures in place to ensure appropriate privacy notices are provided to customers in accordance with Mississippi Regulation 2001-1.

No issues were noted related to the Company's policies, practices and procedures regarding privacy protection and compliance with applicable regulatory requirements.

Complaint Handling

The Company's policies, procedures and practices for handling complaints were reviewed as part of the Market Conduct examination. Management established the Central Escalation Unit ("CEU"), which receives and manages complaints. Through review of the 2021 MID Complaint Log, which included all UHCMS complaints made to the MID throughout 2021, as well as the Company's UHCMS Complaint Log, which included all complaints made to UHCMS during 2021, no discrepancies were noted. Further, for each complaint noted in the UHCMS 2021 complaint log, the complaint documentation evidenced that each complaint was worked

completely and timely, and that appropriate documentation was maintained by the Company.

No issues were noted related to the Company's policies, practices, and procedures regarding complaint handling.

Producer Licensing

For the period under examination, the Company relied upon producers who were licensed and appointed with the MID for commercial healthcare enrollments. The Company has a National Credentialing Department that receives on-boarding information and utilizes SIRCON Software Solutions ("SIRCON"), an external vendor, to register the licensing and appointment or termination of a producer upon request. Producer information is entered into the system and reports are generated and reviewed daily to ensure processing is complete and timely.

During the appointment process, each producer's license is verified to ensure it is valid and active. A judgmentally selected sample of SIRCON daily reports were obtained and reviewed, noting evidence of the tracking and monitoring of SIRCON approvals and that the appointment approval effective dates were within 15 days of the requested effective date or date of policy writing, providing evidence of compliance with Miss. Code Ann. § 83-17-75 (2).

Further, producer termination procedures were reviewed, noting that terminations may be made for routine reasons (i.e., license expiration) or for cause (i.e., violation of laws or regulations). The Credentialing Analyst is responsible for notifying the MID of terminations. A judgmentally selected sample of terminated producers was reviewed to confirm that notices issued to the MID were sent in accordance with Miss. Code Ann. § 83-17-77.

No issues were noted related to the Company's policies, practices and procedures regarding producer appointments, licensing and terminations.

Underwriting and Rating

Patient Protection and Affordable Care Act

Guaranteed Availability and Renewability

The Company's policies and practices for ensuring guaranteed availability and renewability of healthcare plans for individuals and groups under the Patient Protection and Affordable Care Act ("PPACA") were reviewed as part of the Market Conduct examination. The Company established a formal Regulatory Change Management Process ("RCMP") to manage changes with state and federal laws and regulations. Changes are communicated to all impacted business areas so that systems and processes can be updated.

Review of the UHCMS group application appeared to evidence that the Company does not exclude coverage for any person who is eligible under the group. The Group Administrator may choose to exclude certain classes of employees such as union, hourly, non-management, or salary employees, but such decision is made by the Group Administrator and not by the Company. Further, it is the Company's policy that coverage must be renewed in the group and individual market at the option of the plan sponsor or individual, with limited exceptions including: nonpayment of premium, fraud, violation of minimum participation and contribution requirements, or other circumstances

allowed under law.

Individual Enrollment

UHCMS individual healthcare coverage is limited to participation in plans certified by the Health Insurance Marketplace to satisfy PPACA requirements. The Company ensures individuals can purchase its Qualified Health Plan coverage by making the coverage available through its outside broker channel, direct sales unit, and internet marketing channels. In addition, the "on-exchange" plans are available through the following website: www.healthcare.gov.

Small Group Enrollment and Requirements

The Company's underwriting guidelines for Mississippi were reviewed. The Company permits small group employers to enroll at any time during the year, including outside the annual small group open enrollment period. Such guidelines did not appear to include any unallowable enrollment restrictions on small employers.

Group "Employees"

The Company defines employee in accordance with the definitions determined in state and federal law. The Company uses the time period required under the federal law and reinforced by the MS Bulletin 2016-9. The Company ensures necessary systems updates of this information through the RCMP. Generally, the Company calculates the average total number of employees for the employer, without regard to the number of hours the employee works, when determining group size for rating purposes, and the average total number of employees an employer employed on business days during the preceding calendar year is used when determining an employer's group size.

Waiting Period

The Company's Underwriting Guidelines ensure that the Company does not apply any waiting period which exceeds regulatory requirements. Per the Underwriting Guidelines, the waiting period used for group health plans can be one of the following: no waiting period, 1-90 days from date of event, 1-60 days from first of month following administration, or 1-2 months using the date of event or first of month following methods. Under each method, the waiting period does not exceed 90 days and therefore, the Company is in compliance with the ACA waiting period requirements.

Pre-Existing Conditions

The Company's Underwriting Guidelines and policy documentation were reviewed, noting no pre-existing condition exclusions, rendering the Company in compliance with 45 CFR §147.108 and 45 CFR §146.111.

Coverage Discontinuance

The Company has established policies and procedures regarding discontinuance and non-renewal of healthcare coverage. These regulatory requirements are managed through the Company's RCMP.

For discontinuance, the Company follows state and federal regulations to provide access to a similar plan or any other existing plan of the employer's choice. In the case of a market withdrawal,

wherein the MID institutes a marketing ban, the Company is aware a market withdrawal requires a five-year ban, and it would discontinue sales on the license after providing appropriate notices. The Company has systems in place to ensure proper notices are provided directly by the Company. Through review of the discontinuance letter templates, it was noted that the letters offer a similar plan, identifies benefit changes in the plan offered, and informs the business that employees will be sent a notice.

Other Underwriting and Rating Matters

Rate Changes

The Company submits rate changes to the MID via the NAIC's System for Electronic Rates and Forms Filing ("SERFF") and awaits the MID's approval (at least 60 days prior to the proposed effective date) before making rate changes effective in accordance with state law.

Policy Forms

The Company's Policy Form Approval Procedures were reviewed, noting no unusual items or issues. The approval process includes subject matter points of contact and routines for addressing questions and possible objections. The detailed process culminates with a pre-submission review, approval by the MID through the SERFF, and a Company email that is widely distributed and contains form distribution procedures.

Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The Company's policies and practices for administering COBRA benefits to individuals were reviewed as part of the Market Conduct examination. The procedures are such that that timeframes and other requirements for coverage are in compliance with HIPAA. The Company's administration system automatically tracks, monitors, and administrates key aspects of the program, such as a qualifying event, for purposes of tracking the length of COBRA coverage.

No issues were noted related to the Company's policies, practices and procedures regarding underwriting and rating.

Grievance Procedures

The Company established a CEU with policies and procedures to ensure employees appropriately review and resolve clinical and administrative appeals and grievances. Such policies and procedures require the Company to fully investigate the grievance, clearly identify findings, allow the member to review the claim file and present evidence and testimony, and provide the member any new or additional evidence or rationale considered or relied upon in connection with the claim. The CEU utilizes grievance letter templates based on state grievance and appeal requirements that are updated as new state requirements are identified and are tailored to each grievance.

Further, the Company maintains an Escalation Tracking System database to track the review and resolution process of grievances and ensure required response times are met. The database tracks information about grievances including demographics, subject matter and decision-making information including review notes, and documents that are attached or referenced in other systems.

No issues were noted related to the Company's policies, practices, and procedures regarding

grievances.

Network Adequacy

Performance against the established network adequacy standards is monitored by the Company on a weekly basis. The report generated for weekly monitoring provides a breakdown by county, provider specialty type, number of members with access to each specialty type, and brief descriptions of what is being done to rectify instances in which standards are not met. Further, the Company's Provider Administrative Guide includes access standards that participating providers are required to follow, including but not limited to: 24/7 coverage for members, appointment standards (i.e., providers must allow for preventive care appointments within thirty calendar days, routine care appointments within fourteen calendar days, urgent care appointments within the same day, etc.), language services and auxiliary aides, privileges at participating facilities, and more. Such access standards are used to measure participating provider performance annually.

No issues were noted related to the Company's policies, practices and procedures regarding network adequacy.

Provider Credentialing

The Company has established a Credentialing Plan that includes a Mississippi Credentialing Regulatory Addendum. Such plan addresses initial credentialing, re-credentialing and ongoing monitoring and reporting activities.

The NCC has the responsibility to implement the Credentialing Plan, while the Medical Director of each health plan is responsible for the administration of the Credentialing Plan. Each health plan monitors its Licensed Independent Practitioners ("LIPs") and facilities for complaints, potential quality concerns or identified adverse events.

Initial credentialing requires the applicant to meet minimum requirements for location and specialty, medical or professional education and training, malpractice history, and more. LIPs will be recredentialed at least every 36 months which includes completing an application, review of malpractice claims, history of care concerns, compliance with the participation agreement to date, etc. If a LIP's license is suspended at any time, the Company will initiate immediate action to terminate the provider from the network in accordance with the participation agreement.

No issues were noted related to the Company's policies, practices, and procedures regarding provider credentialing.

Claims

The Company's policies, procedures and practices for processing claims were reviewed as part of the Market Conduct examination. The Company maintains a plethora of detailed claims Standard Operating Procedures ("SOPs") that serve as guides with step-by-step instructions for the claims processors. Such SOPs each cover different topics including special claims situations or types, determining whether claims were filed timely, coordinating benefits, etc.

Through review of a sample of claim files, two (2) instances were noted in which the claims were

not paid or denied within 25 days of receipt by UHCMS, constituting a violation of Miss. Code Ann. § 83-9-5(h). The Company acknowledged such finding.

COMMITMENTS AND CONTINGENT LIABILITIES

During and subsequent to the examination period, the Company was not involved in any litigation outside the normal course of business.

SUBSEQUENT EVENTS

Effective January 1, 2022, the Company novated its Centers for Medicare and Medicaid Services contract to affiliate, UnitedHealthcare of Wisconsin, Inc. Approval for this novation was received from CMS and the MID.

Nicholas Robert Shjerve was elected as an officer with the title of Secretary effective June 30, 2022, filling the vacancy in that office due to the departure of Sarah Ann Murdock.

COMMENTS AND RECOMMENDATIONS

Through review of a sample of claim files, two (2) instances were noted in which the claims were not paid or denied within 25 days of receipt by UHCMS, constituting a violation of Miss. Code Ann. § 83-9-5(h).

It is recommended that the Company comply with Miss. Code Ann. § 83-9-5(h).

ACKNOWLEDGMENT

The examiners representing the Mississippi Insurance Department and participating in this examination were:

Examiner-In-Charge:	Vitaliy Kyryk, CFE
Examiner:	Shelby Lambert, CFE, AIE, MCM
Supervising Examiner:	Bill O'Connell, CPA, CFE, CFE (fraud)
Department Designee:	Mark Cooley, CFE

The courteous cooperation of the officers and employees responsible for assisting in the examination is hereby acknowledged and appreciated.

Respectfully submitted,

Vitaliy Kyryk, CFE
Examiner-In-Charge
Noble Consulting Services, Inc.

Mark Cooley

Mark Cooley, CFE
MS Insurance Department Designee