Angelo A. Golemi
Sales Executive – Key Accounts
3100 SW 145th Ave, Suite 200
Miramar, Florida 33027
954.378.0572
angelo_golemi@uhc.com

02/12/2015

Attn: Bid Contacts:

Mr. Ralph Dierks
954-921-3223
RDIERKS@hollywoodfl.org
&
Ms. Linda Silvey
954-921-3200
LSILVEY@hollywoodfl.org

Re: Request for Proposal: The City of Hollywood – Emp Voluntary Group Vision Ins Program – Solicitation RFP-4448-15-RD

Dear Mr. Dierks & Ms. Silvey,

Thank you for the allowing us the opportunity to respond to the City of Hollywood's request for proposal. We are confident that our proposal demonstrates how we can help you achieve your employee benefit plan goals and provide superior cost effective plan administration.

In addition to being named ***"Highest in Customer Satisfaction with Vision Plans"*** **in 2013 by J.D. Power & Associates**, UnitedHealthcare Vision brings several distinct advantages to your Group's Vision offering – including:

- A vast National Network
- Value-added services (Hearing-aid, Lasik discounts, etc.)
- Multi-year Rate Guarantee
- A robust contact lens formulary
- Custom lens option with price-lock guarantees
- 50+ years in Vision experience

Our UnitedHealthcare Vision proposal includes an integrated set of solutions designed to generate improved financial and network strength, and improved Vision health outcomes for the City of Hollywood's employees & their families.

We very much look forward to this opportunity to discussing a strategic partnership with the great City of Hollywood, Florida.

Sincerely,

Angelo A. Golemi
Sales Executive – Key Accounts
UnitedHealthcare of South Florida
angelo_golemi@uhc.com / 954.378.0572

A Vision Benefits Proposal for

City of Hollywood, FL

Due on: February 17, 2015

Issued on: February 13, 2015

UnitedHealthcare®

Statement of Confidentiality

By accepting and reviewing the contents of this Response to the Request for Proposal ("Response"), you and the group health plan and sponsor, and any agents or representatives ("Recipients") agree to the extent permitted by law that certain information contained herein, or other information provided in connection with this request for proposal, is proprietary and/or confidential to UnitedHealth Group, and its related affiliates and entities, and may not be copied, used, distributed or disclosed without prior written consent from an authorized representative of UnitedHealthcare Specialty Benefits, other than what is necessary to evaluate this Response. We consider much of the information contained in the Response to be proprietary or otherwise confidential, and are releasing this Response on the understanding that the Recipients will only use it, and any data included in the Response, for the specific purpose of evaluating its content. If this is not consistent with your understanding, please notify us before reviewing the Response.

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

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1.0 GENERAL TERMS AND CONDITIONS

1.1 INTENT

It is the policy of the City to encourage full and open competition among all available qualified vendors. All vendors regularly engaged in the type of Work specified in the Bid Solicitation are encouraged to submit bids. To receive notification and to be eligible to bid vendor should be registered with BidSync. Vendors may register with the BidSync (registration is free) to be included on a mailing list for selected categories of goods and Services. In order to be processed for payment, any awarded vendor must register with the City by completing and returning a Vendor Application and all supporting documents. For information and to apply as a vendor, please visit our website at hollywoodfl.org to download an application and submit it to Procurement Services Division.

It is the intent of the City of Hollywood, FL ("the City"), through this request for proposals and the contract conditions contained herein, to establish to the greatest possible extent complete clarity regarding the requirements of both parties to the agreement resulting from this request for proposals.

Before submitting a proposal, the Vendor shall be thoroughly familiarized with all contract conditions referred to in this document and any addenda issued before the proposal submission date. Such addenda shall form a part of the RFP and shall be made a part of the contract. It shall be the Vendor's responsibility to ascertain that the proposal includes all addenda issued prior to the proposal submission date. Addenda will be posted on the City's internet site along with the RFP.

The terms of the RFP and the selected Vendor's proposal and any additional documentation (e.g. questions and answers) provided by the Vendor during the solicitation process will be integrated into the final contract for services entered into between the City and the selected Vendor. The Vendor shall determine, by personal examination and by such other means as may be preferred, the conditions and requirements under which the agreement must be performed.

We encourage our fully insured customers to use our filed and approved group policy and COC. Any deviation to the terms and conditions of those documents could potentially require us to conduct a customer-specific filing with the DOI, which would have to be approved by the DOI prior to use.

Under fully insured arrangements, we are not able to incorporate request for proposal terms and conditions into our group policy and COC, which have been filed and approved by appropriate regulatory entities within the state DOI. The group policy and COC contain the necessary mandated benefits and other provisions required by the DOI.

We have provided a **Sample Certificate of Coverage** in **Section 8** of this proposal.

1.2 PROPOSER'S RESPONSIBILITIES

Proposers are required to submit their proposals upon the following express conditions:

A. Proposers shall thoroughly examine the drawings, specifications, schedules, instructions and all other contract documents.

Noted.

B. Proposers shall make all investigations necessary to thoroughly inform themselves regarding delivery of material, equipment or services as required by the RFP conditions. No plea of ignorance, by the proposer, of conditions that exist or that may hereafter exist as a result of failure or omission on the part of the proposer to make the necessary examinations and investigations, or failure to fulfill in every detail the requirements of the contract documents, will be accepted as a basis for varying the requirements of the City or the compensation due the proposer.

Noted.

C. Proposers are advised that all City contracts are subject to all legal requirements provided for in the City of Hollywood Charter, Code of Ordinances and applicable County Ordinances, State Statutes and Federal Statutes.

Noted.

1.3 PREPARATION OF PROPOSALS

Proposals will be prepared in accordance with the following:

A. The City's enclosed Proposal Forms, in their entirety, are to be used in submitting your proposal. NO OTHER FORM WILL BE ACCEPTED.

Noted.

B. All information required by the proposal form shall be furnished. The proposer shall sign each continuation sheet (where indicated) on which an entry is made.

Noted.

C. Prices shall be shown and where there is an error in extension of prices, the unit price shall govern.

The City of Hollywood is exempt from payment to its vendors of State of Florida sales tax and, therefore, such taxes should not be figured into the RFP. However, this exemption does not apply to suppliers to the City in their (supplier) purchases of goods or services, used in work or goods supplied to the City. Proposers are responsible for any taxes, sales or otherwise, levied on their purchases, subcontracts, employment, etc. An exemption certificate will be signed where applicable, upon request. The City will pay no sales tax.

Noted.

1.4 Description of Supplies

Any manufacturer's names, trade names, brand names, or catalog numbers used in these applications are for the purpose of describing and establishing minimum requirements or level of quality, standards of performance, and design required, and are in no way intended to prohibit the bidding of other manufacturers' items of equal material, unless specifications state "NO SUBSTITUTIONS."

Proposers must indicate any variances to the specifications, terms, and conditions, no matter how slight. If variations are not stated in the proposal, it shall be construed that the proposal fully complies with the Specifications, Terms and Conditions.

Proposers are required to state exactly what they intend to furnish; otherwise they shall be required to furnish the items as specified.

Proposers will submit, with their proposal, necessary data (factory information sheets, specifications, brochures, etc.) to evaluate and determine the quality of the item(s) they are proposing.

The City shall be the sole judge of equality and its decision shall be final.

Noted.

1.5 Addenda

The Procurement Services Division may issue an addendum in response to any inquiry received, prior to proposal opening, which changes, adds to or clarifies the terms, provisions or requirements of the solicitation. The Proposer should not rely on any representation, statement or explanation, whether written or verbal, other than those made in this RFP solicitation document or in any addenda issued. Where there appears to be a conflict between this RFP solicitation and any addendum, the last addendum issued shall prevail. It is the proposer's responsibility to ensure receipt of all addenda and any accompanying documents. Proposer(s) shall acknowledge receipt of any formal Addenda by signing the addendum and including it with their proposal. Failure to include signed formal addenda in its proposal shall cause the City to deem the proposal non-responsive provided, however, that the City may waive this requirement in its best interest.

Noted.

1.6 Rejection of Proposals

The City may reject a proposal if:

A. The Proposer fails to acknowledge receipt of an addendum, or if

B. The Proposer misstates or conceals any material fact in the proposal, or if

C. The proposal does not strictly conform to the law or requirements of the RFP, or if

D. The City is under a pre- lawsuit claim or current litigation with the proposer.

The City may reject all Proposals whenever it is deemed in the best interest of the City to do so, and may reject any part of a proposal unless the proposal has been qualified as provided in herein.

Noted.

1.7 WITHDRAWAL OF PROPOSALS

A. Proposals may not be withdrawn and shall be deemed enforceable for a period of 180 days after the time set for the RFP opening.

Our rates are valid for 90 days from February 1, 2015 or April 1, 2015, whichever is sooner.

B. Proposals may be withdrawn prior to the time set for the RFP opening. Such request must be in writing.

Noted.

C. The City will permanently retain as liquidated damages the bid deposit furnished by any proposer who requests to withdraw a proposal after the RFP opening.

Noted.

1.8 PROPOSALS TO REMAIN OPEN

All Proposals shall remain open for 180 calendar days after the day of the Proposal opening, but the City may, at its sole discretion, release any Proposal and return the Proposal Security prior to that date.

Extensions of time when Proposals shall remain open beyond the 180 day period may be made only by mutual written agreement between the City, the successful Proposer and the surety, if any, for the successful Proposer.

Noted.

1.9 LATE PROPOSALS OR MODIFICATIONS

Only proposals received as of the opening date and time will be considered timely. Proposals and modifications received after the time set for the opening will be returned un-opened to the sender and rejected as late.

Noted.

1.10 CONFLICTS WITHIN THE SOLICITATION

Where there appears to be a conflict between the General Terms and Conditions, Special Conditions, the Technical Specifications, the RFP Submittal Section, or any addendum issued, the order of precedence shall be the last addendum issued, the RFP Submittal Section, the Technical Specifications, the Special Conditions, and then the General Terms and Conditions.

Noted.

1.11 Clarification or Objection to Proposal Specifications

If any person contemplating submitting a proposal for this contract is in doubt as to the true meaning of the specifications or other RFP documents or any part thereof, they may submit requests for clarification to the Procurement Services Division on or before the date specified for a request for clarification. All such requests for clarification shall be made in writing and the person submitting the request will be responsible for its prompt delivery. Any interpretation of the RFP, if made, will be made only by Addendum duly issued. A copy of such Addendum will be made available to each person receiving a Request for Proposals. The City will not be responsible for any other explanation or interpretation of the RFP given prior to the award of the contract. Any objection to the specifications and requirements as set forth in this RFP must be filed in writing with the Director of Procurement Services on or before the date specified for a request for clarification.

Noted.

1.12 Competency of Proposers

Pre-award inspection of the Proposer's facility may be made prior to the award of a contract. Proposals will be considered only from firms which are regularly engaged in the business of providing the goods and/or services as described in this RFP(s); have a record of performance for a reasonable period of time; and have sufficient financial support, equipment and organization to ensure that they can satisfactorily deliver the material and/or services if awarded a Contract under the terms and conditions herein stated. The terms "equipment and organization" as used herein shall be construed to mean a fully equipped and well established company in line with the best business practices in the industry and as determined by the proper authorities of the City.

The City may consider any evidence available to it of the financial, technical and other qualifications and abilities of a proposer, including past performance (experience) in making the award in the best interest of the City. In all cases the City of Hollywood shall have no liability to any proposer for any costs or expense incurred in connection with this RFP or otherwise.

Our quotation includes up to $10,000 for a pre-implementation audit. In advance of the audit, we will establish mutually agreed upon pre-implementation audit provisions related to prior notice, confidentiality, scope, length, time, place and the reporting of findings.

External Audit Provisions

We will permit an on-site pre-implementation audit that is consistent with generally acceptable auditing standards, such as a statistically valid, random sample audit that employs acceptable sampling and audit methodologies. Our audit provision provides for the following:

- The time, place, duration and frequency of the audit are reasonable and agreed to by the parties.
- A mutually agreeable third party may be allowed or designated to conduct the audit.
- The audit will be conducted pursuant to agreed-upon confidentiality commitments.
- We will be given a reasonable opportunity to review and comment on any audit conclusions.

1.13 Qualifications of Proposers

No Proposal will be accepted from, nor will any contract be awarded to any person who is in arrears to the City upon any debt or contract, or who is a defaulter, as surety or otherwise, upon any obligation to City, or who is deemed responsible or unreliable by the City.

As part of the Proposal evaluation process, City may conduct a background investigation including a record check by the Hollywood Police Department. Proposer's submission of a Proposal constitutes acknowledgment of the process and consent to such investigation. City shall be the sole judge in determining a Proposer's qualifications.

Noted.

1.14 Consideration of Proposals

In cases where an item requested is identified by a manufacturer's name, trade name, catalog number, or reference, it is understood that the Vendor proposes to furnish the item so identified and does not propose to furnish an "equal" unless the proposed "equal" is pre-approved by the City.

References to any of the above are intended to be descriptive but not restrictive and only indicate articles that will be satisfactory. A proposal of an "equal" will be considered, provided that the Vendor states in his proposal exactly what he proposes to furnish, including sample, illustration, or other descriptive matter which will clearly indicate the character of the article covered by such proposal. The designated City representative hereby reserves the right to approve as an "equal", or to reject as not being an "equal", any article proposed which contains major or minor variations from specifications requirements.

Noted.

1.15 Award of Contract

If the Contract is to be awarded, it will be awarded, after evaluation by the City, to the responsible and responsive Proposer whom the City determines will be in the best interests of the City and not necessarily to the lowest cost Proposer. Proposers may be invited to an oral interview before the committee. A short list of finalists will be determined and presented to either the City Manager or his/her designee or to the City Commission, in accordance with the applicable City of Hollywood Code of Ordinances, and will make the final ranking for the purposes of negotiating a contract with the top ranked firm. The successful Proposer shall be required to sign a negotiated contract; the refusal or failure of a successful Proposer to execute a contract which contains the mandatory material terms and conditions contained in the RFP, shall be grounds for deeming the Proposer and/or the Proposer's Proposal non-responsive.

If applicable, the Proposer to whom award is made shall execute a written contract prior to award by the City Commission. If the Proposer to whom the first award is made fails to enter into a contract as herein provided, the Contract may be let to the next highest ranked Proposer who is responsible and responsive in the opinion of the City.

Noted.

1.16 Basis for Award, Evaluation Criteria and Questions

The qualification of proposal responders on this project will be considered in making the award. The City is not obligated to accept any proposal if deemed not in the best interest of the City to do so. The City shall make award to a qualified proposer based on fees submitted and responses to this RFP.

Failure to include in the proposal all information outlined herein may be cause for rejection of the proposal.

The City reserves the right to accept or reject any and all proposals, in whole or in part, as determined to be in the best interest of the City in its sole discretion.

The City reserves the right to waive any informalities or irregularities in proposals.

The City reserves the right to negotiate separately the terms and conditions or all or any part of the proposals as deemed to be in the City's best interest in its sole discretion.

Information and/or factors gathered during interviews, negotiations and any reference checks, and any other information or factors deemed relevant by the City, shall be utilized in the final award. The final award of a contract is subject to approval by the City Commission.

Noted.

1.17 Agreement

An agreement shall be sent to the awarded proposer to be signed, witnessed, and returned to the City for execution. The City will provide a copy of the fully executed agreement to the awarded proposer.

Noted.

We encourage our fully insured customers to use our filed and approved group policy and COC. Any deviation to the terms and conditions of those documents could potentially require us to conduct a customer-specific filing with the DOI, which would have to be approved by the DOI prior to use.

Under fully insured arrangements, we are not able to incorporate request for proposal terms and conditions into our group policy and certificate of coverage (COC), which have been filed and approved by appropriate regulatory entities within the state Department of Insurance (DOI). The group policy and COC contain the necessary mandated benefits and other provisions required by the DOI.

1.18 Notice to Proceed

A signed purchase order, blanket purchase order or fully executed agreement will be the Proposer's authorization to proceed and may substitute for a "Notice to Proceed" form.

This is not applicable to the services we are proposing to provide to the City of Hollywood, Florida (City of Hollywood). Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

1.19 BID PROTESTS

The City shall provide notice of its intent to award or reject to all Proposers by posting such notice on the City's website.

After a notice of intent to award a contract is posted, any actual or prospective proposer who is aggrieved in connection with the pending award of the contract or any element of the process leading to the award of the contract may protest to the Director of Procurement Services. A protest must be filed within five business days after posting or any right to protest is forfeited. The protest must be in writing, must identify the name and address of the protester, and must include a factual summary of, and the basis for, the protest. Filing shall be considered complete when the protest, including a deposit, is received by the Procurement Services Division. . Failure to file a protest within the time-frame specified herein shall constitute a full waiver of all rights to protest the City's decision regarding the award.

The written protest shall state in detail the specific facts and law or ordinance upon which the protest of the proposed award is based, and shall include all pertinent documents.

A written protest may not challenge the relative weight of evaluation criteria or a formula for assigning points.

Upon receipt of a formal written protest, the City shall stop award proceedings until resolution of the protest; unless it has been determined that the award of the contract without delay is necessary to protect substantial interests of the City.

Any and all costs incurred by a protesting party in connection with a bid protest shall be the sole responsibility of the protesting party.

Upon receipt of a protest of the pending award of a contract, a copy of the protest shall promptly be forwarded to the City Attorney. The City Attorney shall thereupon review the charge to determine its sufficiency, including whether the protest was timely filed. If upon review the City Attorney determines that the charge is insufficient, the City Attorney may issue a summary dismissal of the protest. If upon review the City Attorney determines that the charge is sufficient, a hearing of the protest committee shall be scheduled.

A protest committee shall have the authority to review, settle and resolve the protest. The committee shall consist of three members appointed by the City Manager. The committee's review shall be informal.

If the protest committee determines that the pending award of a contract or any element of the process leading to the award involved a significant violation of law or applicable rule or regulation, all steps necessary and proper to correct the violation shall be taken. If the committee determines that the protest is without merit,

The Director shall promptly issue a decision in writing stating the reason for the decision and furnish a copy to the protester and any other interested party, and the process leading to the award shall proceed.

Noted.

1.20 PREPARATION OF PROPOSALS

Proposals shall be prepared in accordance with the proposal response format. Proposals not complying with this format may be considered non-responsive and may be removed from consideration on this basis.

Requirements for Signing Proposal

A. Each proposer, by making a proposal, represents that this document has been read and is fully understood.

Confirmed.

B. The proposal must be signed in ink by an individual authorized to legally bind the person, partnership, company, or corporation submitting the proposal.

Confirmed.

C. All manual signatures must have the name typed directly under the line of the signature.

Confirmed.

D. The above requirements apply to all RFP addenda.

Confirmed.

1.21 EXAMINATION OF PROPOSAL DOCUMENTS

Before submitting a Proposal, each Proposer must: examine the Proposal Documents thoroughly; consider federal, state and local laws, ordinances, rules and regulations that may in any manner affect cost, progress, performance, or provision of the commodities and/or services; study and carefully correlate Proposer's observations with the Proposal Documents, and notify the City's agent of all conflicts, errors and discrepancies in the Proposal Documents.

The submission of a Proposal will constitute an incontrovertible representation by the Proposer, that the Proposer has complied with every requirement of this RFP, that without exception, the Proposal is premised upon performing the services and/or furnishing the commodities and materials in accordance with such means, methods, techniques, sequences or procedures as may be indicated in or required by the Proposal Documents, and that the Proposal Documents are sufficient in scope and detail to indicate and convey understanding of all terms and conditions of performance and furnishing of the goods and/or services.

Noted.

1.22 PUBLIC RECORDS LAW

If applicable, for each public agency contract for services, the Proposer is required to comply with F.S. 119.0701, which includes the following:

A. Keep and maintain public records that ordinarily and necessarily would be required by the public agency in order to perform the service.

B. Provide the public with access to public records on the same terms and conditions that the public agency would provide the records and at a cost that does not exceed the cost provided in F.S. Chapter 119 or as otherwise provided by law.

C. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law.

D. Meet all requirements for retaining public records and transfer, at no cost, to the public agency, all public records in possession of the proposer upon termination of the contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the public agency in a format that is compatible with the information technology systems of the public agency.

Public records may be inspected and examined by anyone desiring to do so, at a reasonable time, under reasonable conditions, and under supervision by the custodian of the public record. Sealed Proposals become subject to the public records disclosure requirements of F.S. Chapter 119, notwithstanding a proposers' request to the contrary, at the time the City provides notice of a decision or intended decision, or 30 days after the proposal opening, whichever is earlier.

Financial statements submitted in response to a request by the City may be confidential and exempt from disclosure. Data processing software obtained under a licensing agreement which prohibits its disclosure may also exempt.

Proposers are hereby notified and agree that all information submitted as part of, or in support of RFP submittals will be available for public inspection after opening of RFP in compliance with Chapter 119 of the Florida Statutes. The proposer shall not, unless required as part of this RFP, submit any information in response to this invitation which the proposer considers to be a trade secret, proprietary or confidential. The submission, not required as part of this this RFP, of any information to the City in connection with this invitation shall be deemed conclusively to be a waiver of any trade secret or other protection, which would otherwise be available to the proposer.

Confirmed.

1.23 INFORMATION

For information concerning procedure for responding to this Request for Proposal (RFP), contact the Procurement Services Division, Ralph Dierks, Procurement Manager at (954) 921-3223, or Linda Silvey, Budget and Procurement Technician at (954) 921-3200 or Joel Wasserman, Director, Procurement Services at (954) 921-3290, or his designee Such contact is to be for clarification purposes only. Material changes, if any, to the scope of services, or Proposal procedures will only be transmitted by written addendum.

It is preferred that all questions be submitted in writing. Questions should be directed to the City of Hollywood, P.O. Box 229045, Hollywood, Florida 33022-9045, Attention: Ralph Dierks, Procurement Services Division, or to facilitate prompt receipt of questions, they may be sent via fax at (954) 921-3086, or via e-mail to rdierks@hollywoodfl.org or lsilvey@hollywoodfl.org or contact the Director of Procurement Services or his designee.

Noted.

1.24 PROPOSALS

The Proposal must be signed by one duly authorized to do so and in cases where the Proposal is signed by a deputy or subordinate, the principal's proper written grant of authority to such deputy or subordinate must accompany the Proposal. Proposals by corporations must be executed in the corporate name by the President or other corporate officers accompanied by evidence of authority to sign. The corporate address and state of incorporation must be shown below the signature.

Proposals by partnerships must be executed in the partnership name and signed by a general partner whose title must appear under the signature and the official address of the partnership must be shown below the signature.

Noted.

1.25 MODIFICATIONS AND WITHDRAWALS OF PROPOSALS

Proposals must be modified or withdrawn by an appropriate document duly executed in the manner that a Proposal must be executed and delivered to the place where Proposals are to be submitted at any time prior to the deadline for submitting Proposals. A request for withdrawal or a modification must be in writing and signed by a person duly authorized to do so and, in a case where signed by a deputy or subordinate, the principal's proper written grant of authority to such deputy or subordinate must accompany the request for withdrawal or modification. Withdrawal of a Proposal will not prejudice the rights of a Proposer to submit a new Proposal prior to the Proposal date and time. Except where provided in the following paragraph no Proposal may be withdrawn or modified after expiration of the period for receiving Proposals.

If, within twenty-four (24) hours after Proposals are opened, any Proposer files a duly signed written notice with the City and within five (5) calendar days thereafter demonstrates to the reasonable satisfaction of the City by clear and convincing evidence that there was a material and substantial mistake in the preparation of its Proposal, or that the mistake is clearly evident on the face of the Proposal but the intended correct Proposal is not similarly evident, then the Proposer may withdraw its Proposal and the Proposal Security will be returned.

Noted.

1.26 Rejection of Proposals

To the extent permitted by applicable state and federal laws and regulations, the City reserves the right to reject any and all Proposals, to waive any and all informalities, irregularities and technicalities not involving price, time or changes in the commodities and/or services, and the right to disregard all nonconforming, non-responsive, unbalanced or conditional Proposals. Proposals will be considered irregular and may be rejected if they show serious omissions, alterations in form, additions not called for, conditions or unauthorized alterations or irregularities of any kind.

The City also reserves the right to waive minor technical defects in a Proposal. The City reserves the right to determine, in its sole discretion, whether any aspect of a Proposal satisfies the criteria established in this Request for Proposals.

The City reserves the right to reject the Proposal of any Proposer if the City believes that it would not be in the best interest of the City to make an award to that Proposer, whether because the Proposal is not responsive or the Proposer is unqualified or of doubtful financial ability or fails to meet any other pertinent standard or criterion established by City.

The foregoing reasons for rejection of Proposals are not intended to be exhaustive.

Noted.

1.27 Open End Contract

No guarantee is expressed or implied as to the total quantity of commodities/services to be purchased under any open end contract. Estimated quantities will be used for Proposal comparison purposes only. The City reserves the right to issue purchase orders as and when required, or a blanket purchase order and release partial quantities as and when required or any combination of the preceding.

ORDERING: The CITY reserves the right to purchase commodities/services specified herein through Contracts established by other governmental agencies or through separate procurement actions due to unique or special needs. If an urgent delivery is required within a period shorter than the delivery time specified in the contract, and if the seller is unable to comply therewith, the City reserves the right to obtain such delivery from others without penalty or prejudice to the City or to the Proposer.

This is not applicable to the services we are proposing to provide to the City of Hollywood. Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

1.28 Audit Rights

The City reserves the right to audit the records of the successful Proposer for the commodities and/or services provided under the Contract at any time during the performance and term of the Contract and for a period of three (3) years after completion and acceptance by the City. If required by the City, the successful Proposer agrees to submit to an audit by an independent certified public accountant selected by the City. The successful Proposer shall allow the City to inspect, examine and review the records of the successful Proposer in relation to this contract at any and all times during normal business hours during the term of the Contract.

Confirmed with deviation. The City of Hollywood can have external auditors review a sample of paid and denied claims and related claim documentation of your employees and their dependents. Before the audit we ask that you provide:

List of auditors	A list of auditors for us to review and approve.

Time of audit	Together, we choose a time that is convenient for both parties.
Scope and objectives	You send us the scope and objectives at least two months before the audit, so we can prepare the information and adjust staffing. Lead time can be less than two months if claim data tapes or reports are not requested.
Written agreement	We need to have in writing that the audit is necessary for the administration of the plan and the information is confidential and cannot be reproduced, in accordance with HIPAA regulations. Our procedures, systems and information about providers are proprietary information and are not reproduced or divulged to any persons, other than the City of Hollywood, or used for any purpose other than the audit.

We provide five business days to complete the audit, as there is a daily charge if the audit lasts longer than that, or if another audit is done within 12 months of the previous audit.

You are responsible for the costs incurred by you and your representatives in conducting the audit.

1.29 Local, State and Federal Compliance Requirements

The Proposer shall comply with all local, state and federal directives, orders and laws as applicable to this RFP and subsequent contract(s) including, but not limited to:

A. Equal Employment Opportunity (EEO), in compliance with Executive Order 11246 as amended and applicable to this contract.

Confirmed. We strive to maintain a work place that values diversity and accepts and appreciates the differences among our employees. We have included our non-discrimination and affirmative action policies as the **Affirmation Action Policy** attachment in **Section 8** of our proposal.

B. All manufactured items and fabricated assemblies shall comply with applicable requirements of the Occupation Safety and Health Act of 1970 as amended, and be in compliance with Chapter 442, Florida Statutes. Any toxic substance listed in Section 38F-41.03 of the Florida Administrative Code delivered as a result of this order must be accompanied by a completed Material Safety Data Sheet (MSDS).

This is not applicable to the services we are proposing to provide to the City of Hollywood. Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

C. The Immigration and Nationality Act prohibits (i) the employment of an unauthorized alien when the employer knows the individual is an unauthorized alien and (ii) the employment of an individual without complying with the requirements of the federal employment verification system. If a proposer commits either of these violations, such violation shall be cause for unilateral cancellation of the contract.

Confirmed. We confirm that our organization is in compliance with the Immigration and Reform Control Act of 1986.

D. This Section applies only to any contract for goods or services of $1 million or more: The Proposer certifies that it is not on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List and that it does not have business operations in Cuba or Syria as provided in section 287.135, Florida Statutes (2011), as may be amended or revised. The City may terminate this Contract at the City's option if the Proposer is found to have submitted a false certification as provided under subsection (5) of section 287.135, Florida Statutes (2011), as may be amended or revised, or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List or has engaged in business operations in Cuba or Syria, as defined in Section 287.135, Florida Statutes (2011), as may be amended or revised.

This is not applicable to the services we are proposing to provide to the City of Hollywood. Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

1.30 FRAUD AND MISREPRESENTATION

Any individual, corporation or other entity that attempts to meet its contractual obligations with the City through fraud, misrepresentation or material misstatement, may be debarred from doing business with the City. The City as further sanction may terminate or cancel any other contracts with such individual, corporation or entity. Such individual or entity shall be responsible for all direct or indirect costs associated with termination or cancellation, including attorney's fees.

Noted.

1.31 DEBARRED OR SUSPENDED BIDDERS OR PROPOSERS

The proposer certifies, by submission of a response to this solicitation, that neither it nor its principals and subproposers are presently debarred or suspended by any Federal department or agency.

Confirmed.

1.32 COLLUSION

More than one Proposal received for the same work from an individual, firm, partnership, corporation or association under the same or different names will not be considered. Reasonable grounds for believing that any Proposer is interested in more than one Proposal for the same work will cause the rejection of such Proposals in which the Proposer is interested. If there are reasonable grounds for believing that collusion exists among the Proposers, the Proposals of participants in such collusion will not be considered.

Noted.

1.33 COPELAND "ANTI-KICKBACK"

The Proposer and all subproposers will comply with the Copeland Anti-Kickback Act (18 U.S.C. 874) as supplemented in Department of Labor regulations (29 CFR Part 3).

Confirmed.

1.34 Force Majeure

The Agreement which is awarded to the successful proposer may provide that the performance of any act by the City or Proposer hereunder may be delayed or suspended at any time while, but only so long as, either party is hindered in or prevented from performance by acts of God, the elements, war, rebellion, strikes, lockouts or any cause beyond the reasonable control of such party, provided however, the City shall have the right to provide substitute service from third parties or City forces and in such event the City shall withhold payment due the Proposer for such period of time. If the condition of force majeure exceeds a period of 14 days the City may, at its option and discretion, cancel or renegotiate this Agreement.

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

1.35 Public Entity Crimes

A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a proposer, supplier, subproposer, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Florida Statutes, Section 287.017, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list.

Noted.

1.36 Drug-Free Workplace Program

Preference shall be given to businesses with drug-free workplace programs. Whenever two or more proposals which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a proposal received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedures for processing tie proposals will be followed if none of the tied vendors have a drug-free workplace program.

Confirmed. We have a drug-free workplace program and have submitted the drug-free workplace bid form with our proposal.

1.37 Solicitation, Giving, and Acceptance of Gifts Policy

Proposer shall sign and submit the attached form indicating understanding and compliance with the City's and State's policies prohibiting solicitation and acceptance of gifts by public officers, employees and candidates. Failure to submit the signed form will result in your proposal being declared non-responsive; provided, however, that a responsible proposer whose proposal would be responsive but for the failure to submit the signed form in its proposal may be given the opportunity to submit the form to the City within five calendar days after notification by the City, if this is determined to be in the best interest of the City.

Confirmed.

1.38 Conflict of Interest

The Proposer represents that:

No officer, director, employee, agent, or other consultant of the City or a member of the immediate family or household of the aforesaid has directly or indirectly received or been promised any form of benefit, payment or compensation, whether tangible or intangible, in connection with the grant of this Agreement.

There are no undisclosed persons or entities interested with the Proposer in this Agreement. This Agreement is entered into by the Proposer without any connection with any other entity or person making a proposal for the same purpose, and without collusion, fraud or conflict of interest. No elected or appointed officer or official, director, employee, agent or other consultant of the City, or of the State of Florida (including elected and appointed members of the legislative and executive branches of government), or member of the immediate family or household of any of the aforesaid:

1. **Is interested on behalf of or through the Proposer directly or indirectly in any manner whatsoever in the execution or the performance of this Agreement, or in the services, supplies or work, to which this Agreement relates or in any portion of the revenues; or**

2. **Is an employee, agent, advisor, or consultant to the Proposer or to the best of the Proposer's knowledge, any subproposer or supplier to the Proposer.**

Neither the Proposer nor any officer, director, employee, agent, parent, subsidiary, or affiliate of the Proposer shall have an interest which is in conflict with the Proposer's faithful performance of its obligations under this Agreement; provided that the City, in its sole discretion, may consent in writing to such a relationship, and provided the Proposer provides the City with a written notice, in advance, which identifies all the individuals and entities involved and sets forth in detail the nature of the relationship and why it is in the City's best interest to consent to such relationship.

The provisions of this Article are supplemental to, not in lieu of, all applicable laws with respect to conflict of interest. In the event there is a difference between the standards applicable under this Agreement and those provided by statute, the stricter standard shall apply.

In the event the Proposer has no prior knowledge of a conflict of interest as set forth above and acquires information which may indicate that there may be an actual or apparent violation of any of the above, the Proposer shall promptly bring such information to the attention of the City's Project Manager. The Proposer shall thereafter cooperate with the City's review and investigation of such information, and comply with the instructions the Proposer receives from the Project Manager in regard to remedying the situation.

To the best of our knowledge, no elected or appointed officials of the State of Florida are interested in this RFP, or are employed by UnitedHealthcare Insurance Company.

1.39 Discrimination

Any entity or affiliate who has been placed on the discriminatory vendor list may not submit a proposal on a contract to provide goods or services to a public entity, may not submit a proposal on a contract with a public entity for construction or repair of a public building or public work, may not submit proposals on leases of real property to a public entity, may not award or perform work as a proposer, supplier, subproposer, or consultant under contract with any public entity, and may not transact business with any public entity.

Noted.

1.40 Advice of Omission or Misstatement

In the event it is evident to a Vendor responding to this RFP that the City has omitted or misstated a material requirement to this RFP and/or the services required by this RFP, the responding Vendor shall advise the contact identified in the RFP Clarifications and Questions section above of such omission or misstatement.

Noted.

1.41 Confidential Information

Information contained in the Vendor's proposal that is company confidential must be clearly identified in the proposal itself. The City will be free to use all information in the Vendor's proposal for the City's purposes, in accordance with State Law. Vendor proposals shall remain confidential for 30 days or until a notice of intent to award is posted, which is sooner. The Vendor understands that any material supplied to the City may be subject to public disclosure under the Public Records Law.

Noted.

1.42 Governing Law

This Contract, including appendices, and all matters relating to this Contract (whether in contract, statute, tort (such as negligence), or otherwise) shall be governed by, and construed in accordance with, the laws of the State of Florida. This shall apply notwithstanding such factors which include, but are not limited to, the place where the contract is entered into, the place where the accident occurs and not withstanding application of conflicts of law principles.

Our agreement will be governed by ERISA and, if applicable, the laws of Florida.

1.43 Litigation Venue

The parties waive the privilege of venue and agree that all litigation between them in the state courts shall take place in Broward County, Florida and that all litigation between them in the federal courts shall take place in the Southern District of Florida.

Mediation is our preferred means for resolving commercial disputes, with a final outlet to court. We believe it is in the best interests of both parties to not restrict actions to any one particular venue.

1.44 Sovereign Immunity

Nothing in this agreement shall be interpreted or construed to mean that the city waives its common law sovereign immunity or the limits of liability set forth in Section 768.28, Florida Statute.

Noted.

1.45 Survival

The parties acknowledge that any of the obligations in this Agreement will survive the term, termination and cancellation hereof. Accordingly, the respective obligations of the Proposer and the City under this Agreement, which by nature would continue beyond the termination, cancellation or expiration thereof, shall survive termination, cancellation or expiration hereof.

We generally request 60-days' prior written notice in the event of contract termination. Our vision plans are not portable; therefore, a member who terminates is not eligible for coverage. However, we do pay any outstanding claims for services rendered prior to termination.

1.46 INDEMNIFICATION AND HOLD HARMLESS AGREEMENT

The Contractor shall indemnify and hold harmless the City of Hollywood and its officers, employees, agents and instrumentalities from any and all liability, losses or damages. In addition, the City shall be entitled to attorney's fees and costs of defense, which the City of Hollywood, or its officers, employees, agents or instrumentalities may incur as a result of claims, demands, suits, causes of actions or proceedings of any kind or nature arising out of, relating to or resulting from the performance of this project by the awarded proposer or its employees, agents, servants, partners, principals or subcontractors. Furthermore, the awarded proposer shall pay all claims and losses in connection therewith and shall investigate and defend all claims, suits or actions of any kind of nature in the name of the City of Hollywood, where applicable, including appellate proceedings, and shall pay all costs, judgments, and attorney's fees which may issue thereon. The awarded proposer expressly understands and agrees that any insurance protection required by the resulting agreement or otherwise provided by the awarded proposer shall cover the City of Hollywood, its officers, employees, agents and instrumentalities and shall include claims for damages resulting from and/or caused by the negligence, recklessness or intentional wrongful misconduct of the Contractor and persons employed by or utilized by the Contractor in the performance of the contract.

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

1.47 Patent and Copyright Indemnification

The Proposer warrants that all deliverables furnished hereunder, including but not limited to: services, equipment programs, documentation, software, analyses, applications, methods, ways, processes, and the like, do not infringe upon or violate any patent, copyrights, service marks, trade secret, or any other third party proprietary rights.

The Proposer shall be liable and responsible for any and all claims made against the City for infringement of patents, copyrights, service marks, trade secrets or any other third party proprietary rights, by the use or supplying of any programs, documentation, software, analyses, applications, methods, ways, processes, and the like, in the course of performance or completion of, or in any way connected with, the work, or the City's continued use of the deliverables furnished hereunder. Accordingly, the Proposer, at its own expense, including the payment of attorney's fees, shall indemnify, and hold harmless the City and defend any action brought against the City with respect to any claim, demand, and cause of action, debt, or liability.

In the event any deliverable or anything provided to the City hereunder, or a portion thereof, is held to constitute an infringement and its use is or may be enjoined, the Proposer shall have the obligation, at the City's option, to (i) modify, or require that the applicable subproposer or supplier modify, the alleged infringing item(s) at the Proposer's expense, without impairing in any respect the functionality or performance of the item(s), or (ii) procure for the City, at the Proposer's expense, the rights provided under this Agreement to use the item(s).

The Proposer shall be solely responsible for determining and informing the City whether a prospective supplier or subproposer is a party to any litigation involving patent or copyright infringement, service mark, trademark, violation, or proprietary rights claims or is subject to any injunction which may prohibit it from providing any deliverable hereunder. The Proposer shall enter into agreements with all suppliers and subproposers at the Proposer's own risk. The City may reject any deliverable that it believes to be the subject of any such litigation or injunction, or if, in the City's judgment, use thereof would delay the work or be unlawful.

The Proposer shall not infringe any copyright, trademark, service mark, trade secrets, patent rights, or other intellectual property rights in the performance of the work.

It is not contemplated that works or inventions will be created by us on behalf of the customer. Our services are universally provided to our entire book of business, and not created through a means that would pass title or ownership to any one customer.

1.48 Advertising

Vendor shall not advertise or publish the fact that the City has placed this order without prior written consent from the City, except as may be necessary to comply with a proper request for information from an authorized representative of a governmental unit or agency.

Confirmed.

1.49 DISCLAIMER

The Hollywood may, in its sole discretion, accept or reject, in whole or in part, for any reason whatsoever any or all proposals; re-advertise this RFP, postpone or cancel at any time this RFP process; or, waive any formalities of or irregularities in the proposal process. Proposals that are not submitted on time and/or do not conform to the City of Hollywood's requirements will not be considered. After all proposals are analyzed, organization(s) submitting proposal that appear, solely in the opinion of the City of Hollywood, to be the most competitive, shall be submitted to the City of Hollywood's City Commission, and the final selection will be made shortly thereafter with a timetable set solely by the City of Hollywood. The selection by the City of Hollywood shall be based on the proposal, which is, in the sole opinion of the City Commission of the City of Hollywood, in the best interest of the City of Hollywood. The issuance of this RFP constitutes only an invitation to make a proposal to the City of Hollywood. The City of Hollywood reserves the right to determine, in its sole discretion, whether any aspect of the proposal satisfies the criteria established by the City. In all cases the City of Hollywood shall have no liability to any proposer for any costs or expense incurred in connection with this proposal or otherwise.

Noted.

1.50 TRADEMARKS

The City warrants that all trademarks the City requests the Vendor to affix to articles purchased are those owned by the City and it is understood that the Vendor shall not acquire or claim any rights, title, or interest therein, or use any of such trademarks on any articles produced for itself or anyone other than the City.

Noted.

1.51 RIGHT TO REQUEST ADDITIONAL INFORMATION

The City reserves the right to request any additional information that might be deemed necessary during the evaluation process.

Noted.

1.52 PROPOSAL PREPARATION COSTS

The Vendor is responsible for any and all costs incurred by the Vendor or his/her subproposers in responding to this request for proposals.

Confirmed.

1.53 DESIGN COSTS

The successful Vendor shall be responsible for all design, information gathering, and required programming to achieve a successful implementation. This cost must be included in the base proposal.

Confirmed.

1.54 Additional Charges

No additional charges, other than those listed on the price breakdown sheets, shall be made. Prices quoted will include verification/coordination of order, all costs for shipping, delivery to all sites, unpacking, setup, installation, operation, testing, cleanup, training and Vendor travel charges.

Please refer to the financial commentary included with this proposal. We do not anticipate circumstances that might result in a rate change during the guarantee period, unless initial enrollment varies by more than 10 percent from the census data on which we based the quote.

1.55 Rights to pertinent Materials

All responses, inquires, and correspondence relating to this RFP and all reports, charts, displays, schedules, exhibits and other documentation produced by the Vendor that are submitted as part of the proposal shall become the property of the City upon receipt, a part of a public record upon opening, and will not be returned.

Noted. This proposal is provided in response to a request to bid; information included in the proposal is to be used only in that context.

1.56 Nature of the Agreement

The Agreement incorporates and includes all negotiations, correspondence, conversations, agreements, and understandings applicable to the matters contained in the Agreement. The parties agree that there are no commitments, agreements, or understandings concerning the subject matter of the Agreement that are not contained in the Agreement, and that the Agreement contains the entire agreement between the parties as to all matters contained herein. Accordingly, it is agreed that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written. It is further agreed that any oral representations or modifications concerning this Agreement shall be of no force or effect, and that the Agreement may be modified, altered or amended only by a written amendment duly executed by both parties hereto or their authorized representatives.

The Proposer shall provide the services set forth in the Scope of Services, and render full and prompt cooperation with the City in all aspects of the services performed hereunder.

The Proposer acknowledges that the Agreement requires the performance of all things necessary for or incidental to the effective and complete performance of all work and services under this Contract. All things not expressly mentioned in the Agreement but necessary to carrying out its intent are required by the Agreement, and the Proposer shall perform the same as though they were specifically mentioned, described and delineated.

The Proposer shall furnish all labor, materials, tools, supplies, and other items required to perform the work and services that are necessary for the completion of this Contract. All work and services shall be accomplished at the direction of and to the satisfaction of the City's Project Manager.

The Proposer acknowledges that the City shall be responsible for making all policy decisions regarding the Scope of Services. The Proposer agrees to provide input on policy issues in the form of recommendations.

The Proposer agrees to implement any and all changes in providing services hereunder as a result of a policy change implemented by the City. The Proposer agrees to act in an expeditious and fiscally sound manner in providing the City with input regarding the time and cost to implement said changes and in executing the activities required to implement said changes

Under fully insured arrangements, we are not able to incorporate request for proposal terms and conditions into our group policy and COC, which have been filed and approved by appropriate regulatory entities within the state DOI. The group policy and COC contain the necessary mandated benefits and other provisions required by the DOI.

We encourage our fully insured customers to use our filed and approved group policy and COC. Any deviation to the terms and conditions of those documents could potentially require us to conduct a customer-specific filing with the DOI, which would have to be approved by the DOI prior to use.

1.57 Authority of the City's Project Manager

The Proposer hereby acknowledges that the City's Project Manager will determine in the first instance all questions of any nature whatsoever arising out of, under, or in connection with, or in any way related to or on account of, this Agreement including without limitations: questions as to the value, acceptability and fitness of the services; questions as to either party's fulfillment of its obligations under the Contract; negligence, fraud or misrepresentation before or subsequent to acceptance of the Proposal; questions as to the interpretation of the Scope of Services; and claims for damages, compensation and losses.

The Proposer shall be bound by all determinations or orders and shall promptly obey and follow every order of the Project Manager, including the withdrawal or modification of any previous order and regardless of whether the Proposer agrees with the Project Manager's determination or order. Where orders are given orally, they will be issued in writing by the Project Manager as soon thereafter as is practicable.

The Proposer must, in the final instance, seek to resolve every difference concerning the Agreement with the Project Manager. In the event that the Project Manager and the Proposer are unable to resolve their difference, the Proposer may initiate a dispute in accordance with the procedures set forth in the section below. Exhaustion of these procedures shall be a condition precedent to any lawsuit permitted hereunder.

In the event of such dispute, the parties to this Agreement authorize the City Manager or designee, who may not be the Project Manager or anyone associated with this Project, acting personally, to decide all questions arising out of, under, or in connection with, or in any way related to or on account of the Agreement (including but not limited to claims in the nature of breach of contract, fraud or misrepresentation arising either before or subsequent to execution hereof) and the decision of each with respect to matters within the City Manager's purview as set forth above shall be conclusive, final and binding on the parties. Any such dispute shall be brought, if at all, before the City Manager within 10 days of the occurrence, event or act out of which the dispute arises.

The City Manager may base this decision on such assistance as may be desirable, including advice of experts, but in any event shall base the decision on an independent and objective determination of whether the Proposer's performance or any deliverable meets the requirements of this Agreement and any specifications with respect thereto set forth herein. The effect of any decision shall not be impaired or waived by any negotiations or settlements or offers made in connection with the dispute, whether or not the City Manager participated therein, or by any prior decision of others, which prior decision shall be deemed subject to review, or by any termination or cancellation of the Agreement. All such disputes shall be submitted in writing by the Proposer to the City Manager for a decision, together with all pertinent information in regard to such questions, in order that a fair and impartial decision may be made. The parties agree that whenever the City Manager is entitled to exercise discretion or judgment or to make a determination or form an opinion pursuant to the provisions of this Article, such action shall be deemed fair and impartial when exercised or taken. The City Manager shall render a decision in writing and deliver a copy of the same to the Proposer. Except as such remedies may be limited or waived elsewhere in the Agreement, the Proposer reserves the right to pursue any remedies available under law after exhausting the provisions of this Article.

This is not applicable to the services we are proposing to provide to the City of Hollywood. Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

1.58 MUTUAL OBLIGATIONS

This Agreement, including attachments and appendices to the Agreement, shall constitute the entire Agreement between the parties with respect hereto and supersedes all previous communications and representations or agreements, whether written or oral, with respect to the subject matter hereof unless acknowledged in writing by the duly authorized representatives of both parties.

Nothing in this Agreement shall be construed for the benefit, intended or otherwise, of any third party that is not a parent or subsidiary of a party or otherwise related (by virtue of ownership control or statutory control) to a party.

In those situations where this Agreement imposes an indemnity or defense obligation on the Proposer, the City may, at its expense, elect to participate in the defense if the City should so choose. Furthermore, the City may at its own expense defend or settle any such claims if the Proposer fails to diligently defend such claims, and thereafter seek indemnity for costs and attorney's fees from the Proposer.

Under fully insured arrangements, we are not able to incorporate request for proposal terms and conditions into our group policy and COC, which have been filed and approved by appropriate regulatory entities within the state DOI. The group policy and COC contain the necessary mandated benefits and other provisions required by the DOI.

We encourage our fully insured customers to use our filed and approved group policy and COC. Any deviation to the terms and conditions of those documents could potentially require us to conduct a customer-specific filing with the DOI, which would have to be approved by the DOI prior to use.

1.59 SUBCONTRACTUAL RELATIONS

If the Proposer will cause any part of this Agreement to be performed by a subproposer, the provisions of this Contract will apply to such subproposer and its officers, agents and employees in all respects as if it and they were employees of the Proposer; and the Proposer will not be in any manner thereby discharged from its obligations and liabilities hereunder, but will be liable hereunder for all acts and negligence of the subproposer, its officers, agents, and employees, as if they were employees of the Proposer. The services performed by the subproposer will be subject to the provisions hereof as if performed directly by the Proposer.

The Proposer, before making any subcontract for any portion of the services, will state in writing to the City the name of the proposed subproposer, the portion of the services which the subproposer is to do, the place of business of such subproposer, and such other information as the City may require. The City will have the right to require the Proposer not to award any subcontract to a person, firm or corporation disapproved by the City.

Before entering into any subcontract hereunder, the Proposer will inform the subproposer fully and completely of all provisions and requirements of this Agreement relating either directly or indirectly to the services to be performed. Such services performed by such subproposer will strictly comply with the requirements of this Contract.

In order to qualify as a subproposer satisfactory to the City, in addition to the other requirements herein provided, the subproposer must be prepared to prove to the satisfaction of the City that it has the necessary facilities, skill and experience, and ample financial resources to perform the services in a satisfactory manner. To be considered skilled and experienced, the subproposer must show to the satisfaction of the City that it has satisfactorily performed services of the same general type which are required to be performed under this Agreement.

The City shall have the right to withdraw its consent to a subcontract if it appears to the City that the subcontract will delay, prevent, or otherwise impair the performance of the Proposer's obligations under this Agreement. All subproposers are required to protect the confidentiality of the City and City's proprietary and confidential information. The Proposer shall furnish to the City copies of all subcontracts between the Proposer and subproposers and suppliers hereunder. Within each such subcontract, there shall be a clause for the benefit of the City permitting the City to request completion of performance by the subproposer of its obligations under the subcontract, in the event the City finds the Proposer in breach of its obligations, and the option to pay the subproposer directly for the performance by such subproposer. The foregoing shall neither convey nor imply any obligation or liability on the part of the City to any subproposer hereunder as more fully described herein.

We consider the following information to be proprietary or otherwise confidential, and are releasing this proposal to you on the understanding that you and your representatives will only use it, and any data included in the proposal, for the specific purpose of evaluating its content.

We do not anticipate the need to make subcontracting arrangements specific to your account. We deliver our core services directly through the UnitedHealth Group Incorporated family of companies, allowing us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

We also work with a variety of external vendors and subcontractors during the normal course of providing services to our entire book of business. We accept responsibility to the extent that a subcontracted vendor fails to meet any contractual obligation assumed by us.

Our individual contracts with each subcontractor define the payment methodology, timing and process. Contract details, including payment terms, are considered proprietary and are only disclosed to the parties governed by the contract terms.

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

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

We subcontract with the following non-affiliated organizations:

- **GfK Custom Research** conducts our member surveys. We have been working with GfK since 2010.
- **LCA-Vision** provides discounted laser correction surgery for members through the Laser Vision Network of America (LVNA). We have been working with LCA-Vision since 2004.
- **Essilor** supports our company-owned optical laboratory by filling orders for their proprietary products. We have been working with Essilor since 2006.
- **HOYA** supports our company-owned optical laboratory by filling orders for their proprietary products. We have been working with HOYA since 2006.
- **Zeiss** supports our company-owned optical laboratory by filling orders for their proprietary products. We have been working with Zeiss since 2006.
- **SourceHOV** (formerly HOV Services) receives and images paper claims. UnitedHealth Group has used this subcontractor since 1998, and we began using HOV Services for vision claims in 2005.
- **TeleTech** receives all incoming provider phone calls in Lipa City, Philippines. UnitedHealth Group has used this subcontractor since 1996, and we began using TeleTech for vision provider calls in 2005.
- **Cognizant Technology Solutions**' contractors work at our Columbia, Maryland, offices for IT development, support and maintenance for vision core benefit administrative system and associated web portals. We have been working with Cognizant for vision services since 2005.

1.60 PROMPT PAYMENT: LATE PAYMENTS BY PROPOSER TO SUBPROPOSER AND MATERIAL SUPPLIERS; PENALTY:

When a proposer receives from the City of Hollywood any payment for contractual services, commodities, materials, supplies, or construction contracts, the proposer shall pay such moneys received to each subproposer and material supplier in proportion to the percentage of work completed by each subproposer and material supplier at the time of receipt. If the proposer receives less than full payment, then the proposer shall be required to disburse only the funds received on a pro rata basis to the subproposers and materials Suppliers, each receiving a prorated portion based on the amount due on the payment. If the proposer without reasonable cause fails to make payments required by this section to subproposers and material suppliers within fifteen (15) working days after the receipt by the proposer of full or partial payment, the proposer shall pay to the subproposers and material suppliers a penalty in the amount of one percent (1%) of the amount due, per month, from the expiration of the period allowed herein for payment. Such penalty shall be in addition to actual payments owed. Retainage is also subject to the prompt payment requirement and must be returned to the subproposer or material supplier whose work has been completed, even if the prime contract has not been completed. The Proposer shall include the above obligation in each subcontract it signs with a subproposer or material suppler.

This is not applicable to the services we are proposing to provide to the City of Hollywood. Our agreements are not traditional goods agreements; they are based on a complex array of services that are uniquely packaged to fit each individual customer's needs.

Our individual contracts with each subcontractor define the payment methodology, timing and process. Contract details, including payment terms, are considered proprietary and are only disclosed to the parties governed by the contract terms.

1.61 TERMINATION FOR CONVENIENCE AND SUSPENSION OF WORK

The City may terminate this Agreement if an individual or corporation or other entity attempts to meet its contractual obligation with the City through fraud, misrepresentation or material misstatement.

The City may, as a further sanction, terminate or cancel any other contract(s) that such individual or corporati on or other entity has with the City. Such individual, corporation or other entity shall be responsible for all direct and indirect costs associated with such termination or cancellation, including attorney's fees.

The foregoing notwithstanding, any individual, corporation or other entity which attempts to meet its contractual obligations with the City through fraud, misrepresentation or material misstatement may be debarred from City contracting in accordance with the City debarment procedures. The Proposer may be subject to debarment for failure to perform and any other reasons related to the proposer's breach or failure of satisfactory performance.

In addition to cancellation or termination as otherwise provided in this Agreement, the City may at any time, in its sole discretion, with or without cause, terminate this Agreement by written notice to the Proposer and in such event:

The Proposer shall, upon receipt of such notice, unless otherwise directed by the City:

1. **Stop work on the date specified in the notice ("the Effective Termination Date");**
2. **Take such action as may be necessary for the protection and preservation of the City's materials and property;**
3. **Cancel orders;**

4. **Assign to the City and deliver to any location designated by the City any non-cancelable orders for deliverables that are not capable of use except in the performance of this Agreement and which have been specifically developed for the sole purpose of this Agreement and not incorporated in the services;**

5. **Take no action which will increase the amounts payable by the City under this Agreement.**

In the event that the City exercises its right to terminate this Agreement pursuant to this Article, the Proposer will be compensated as stated in the payment articles herein, for the:

1. **Portion of the services completed in accordance with the Agreement up to the Effective Termination Date; and**

2. **Non-cancelable deliverables that are not capable of use except in the performance of this Agreement and which have been specifically developed for the sole purpose of this Agreement but not incorporated in the services.**

All compensation pursuant to this Article is subject to audit.

Under a fully-insured arrangement, we assume risk for claims incurred during the benefit period and will process and pay such claims even if submitted after the contract is terminated, provided they are submitted within 12 months of the date of service.

We can accommodate prior written external audit requests during normal business hours. The audit's scope will be determined at the time of request, taking into account your needs, HIPAA privacy requirements and other applicable regulations and any internal business policies. Typically the customer bears the cost of a requested external audit.

1.62 EVENT OF DEFAULT

An Event of Default shall mean a breach of this Agreement by the Proposer. Without limiting the generality of the foregoing and in addition to those instances referred to herein as a breach, an Event of Default, shall include the following:

1. **The Proposer has not delivered deliverables on a timely basis;**

2. **The Proposer has refused or failed, except in any case for which an extension of time is provided, to supply enough properly skilled staff personnel;**

3. **The Proposer has failed to make prompt payment to subproposers or suppliers for any devices;**

4. **The Proposer has become insolvent (other than as interdicted by the bankruptcy laws), or has assigned the proceeds received for the benefit of the Proposer's creditors, or the Proposer has taken advantage of any insolvency statute or debtor/creditor law or if the Proposer's affairs have been put in the hands of a receiver;**

5. **The Proposer has failed to obtain the approval of the City where required by this Agreement;**

6. **The Proposer has failed to provide "adequate assurances" as required under subsection "B" below; and**

7. **The Proposer has failed in the representation of any warranties stated herein.**

When, in the opinion of the City, reasonable grounds for uncertainty exist with respect to the Proposer's ability to perform the services or any portion thereof, the City may request that the Proposer, within the time frame set forth in the City's request, provide adequate assurances to the City, in writing, of the Proposer's ability to perform in accordance with terms of this Agreement. Until the City receives such assurances the City may request an adjustment to the compensation received by the Proposer for portions of the services which the Proposer has not performed. In the event that the Proposer fails to provide to the City the requested assurances within the prescribed time frame, the City may:

1. **Treat such failure as a repudiation of this Agreement;**
2. **Resort to any remedy for breach provided herein or at law, including but not limited to, taking over the performance of the services or any part thereof either by itself or through others.**

In the event the City shall terminate this Agreement for default, the City or its designated representatives may immediately take possession of all applicable equipment, materials, products, documentation, reports and data.

The contract will terminate upon the conclusion of the contract or upon at least 60 days prior written notice of termination from either party. Either party can terminate the contract for material breach of the agreement. We can terminate the agreement for non-payment of fees or other amounts. We do not impose penalties for off-anniversary cancellations.

Upon termination, we transfer all necessary information to the succeeding carrier or third-party administrator in accordance with applicable state and federal law. If the City of Hollywood desires more data, particularly historical claim files, we negotiate an agreement. We would require a hold harmless agreement for the release of information.

1.63 REMEDIES IN THE EVENT OF DEFAULT

If an Event of Default occurs, the Proposer shall be liable for all damages resulting from the default, including but not limited to:

A. **Lost revenues;**

B. **The difference between the cost associated with procuring services hereunder and the amount actually expended by the City for procurement of services, including procurement and administrative costs; and,**

C. **Such other damages that the City may suffer.**

The Proposer shall also remain liable for any liabilities and claims related to the Proposer's default. The City may also bring any suit or proceeding for specific performance or for an injunction.

Our contracts contain specific language outlining financial responsibility for overpayments dealing with intentional acts or gross negligence on the part of our company. If state- specific legislation addressing this circumstance exists, it would be part of the proposed or existing contract. We thoroughly investigate any situation brought to our attention to determine if a mistake has been made. Members and providers always have the right to appeal and a full investigation would be conducted at that time.

Due to the unique nature of the arrangement, it is not an appropriate remedy for the customer to offset premium payments due us from any amounts the customer believes it is owed. As an alternative, we would prefer that the parties meet to discuss any failures and mutually agree to a resolution.

1.64 BANKRUPTCY

The City reserves the right to terminate this contract if, during the term of any contract the Proposer has with the City, the Proposer becomes involved as a debtor in a bankruptcy proceeding, or becomes involved in a reorganization, dissolution, or liquidation proceeding, or if a trustee or receiver is appointed over all or a substantial portion of the property of the Proposer under federal bankruptcy law or any state insolvency law.

Confirmed. The contract will terminate upon the conclusion of the contract or upon at least 60 days prior written notice of termination from either party. Either party can terminate the contract for material breach of the agreement.

1.65 CANCELLATION FOR UNAPPROPRIATED FUNDS

The obligation of the City for payment to a Proposer is limited to the availability of funds appropriated in a current fiscal period, and continuation of the contract into a subsequent fiscal period is subject to appropriation of funds, unless otherwise authorized by law.

Upon any termination of the group policy, the customer shall be and shall remain liable to us for the payment of any and all premiums that are unpaid at the time of termination, including a pro rata fee for any period this policy was in force during the grace period preceding the termination.

1.66 VERBAL INSTRUCTIONS PROCEDURE

No negotiations, decisions, or actions shall be initiated or executed by the Proposer as a result of any discussions with any City employee. Only those communications which are in writing from an authorized City representative may be considered. Only written communications from Proposers, which are signed by a person designated as authorized to bind the Proposer, will be recognized by the City as duly authorized expressions on behalf of the Proposer.

Noted.

1.67 E-VERIFY

Proposer acknowledges that the City may be utilizing the Proposer's services for a project that is funded in whole or in part by State funds pursuant to a contract between the City and a State agency. The Proposer shall be responsible for complying with the E-Verify requirements in the contract and using the U.S. Department of Homeland Security's E-Verify system to verify the employment of all new employees hired by the Proposer during the Agreement term. The Proposer is also responsible for e-verifying its subproposers, if any, pursuant to any agreement between the City and a State Agency, and reporting to the City any required information. The Proposer acknowledges that the terms of this paragraph are material terms, the breach of any of which shall constitute a default under this Agreement.

Confirmed.

1.68 BUDGETARY CONSTRAINTS

In the event the City is required to reduce contract costs due to budgetary constraints, all services specified in this document may be subject to a permanent or temporary reduction in budget. In such an event, the total cost for the affected service shall be reduced as required. The Proposer shall also be provided with a minimum 30-day notice prior to any such reduction in budget.

Upon any termination of the group policy, the customer shall be and shall remain liable to us for the payment of any and all premiums that are unpaid at the time of termination, including a pro rata fee for any period this policy was in force during the grace period preceding the termination.

1.69 Cost Adjustments

The cost for all items as quoted herein shall remain firm for the first term of the contract. Costs for subsequent years and any extension term years shall be subject to an adjustment only if increases occur in the industry. However, unless very unusual and significant changes have occurred in the industry, such increases shall not exceed 3% per year or, whichever is less, the latest yearly percentage increase in the All Urban Consumers Price Index (CPU-U) (National) as published by the Bureau of Labor Statistics, U.S. Dept. of Labor. The yearly increase or decrease in the CPI shall be that latest index published and available ninety (90) days prior to the end of the contract year than in effect compared to the index for the same month one year prior. Any requested cost increase shall be fully documented and submitted to the City at least ninety (90) days prior to the contract anniversary date. Any approved cost adjustments shall become effective upon the anniversary date of the contract. In the event the CPI or industry costs decline, the City shall have the right to receive from the Proposer a reduction in costs that reflects such cost changes in the industry. The City may, after examination, refuse to accept the adjusted costs if they are not properly documented, increases are considered to be excessive, or decreases are considered to be insufficient. In the event the City does not wish to accept the adjusted costs and the matter cannot be resolved to the satisfaction of the City, the contract can be cancelled by the City upon giving thirty (30) days written notice to the Proposer.

Upon expiration of the initial rate guarantee, 21 months expiring December 31, 2016, we will issue a full renewal based upon the experience for this group. We would be willing to provide 90 days advance notice of any change.

Scope of Services / Specifications / Proposer Qualifications:

(Information must be included with your proposal – as applicable)

1. **Fully insured 100% voluntary benefit plan with an effective date of April 1, 2015.**

   Confirmed.

2. **Rate guarantee with stable benefits. Rate/benefit adjustments during the stipulated period for coverage will result in termination of contract.**

   Confirmed. Rates will only change if the benefit design, census, effective date, etc. should change.

3. **ALL participation requirements must be stated together with any potential for rate change based upon participation.**

   Our quote is a voluntary quote with no minimum participation requirements.

4. **Benefits shall match existing plan or better.**

   We have quoted a triple option and a dual option. Please see proposal for disclosure of our benefit design.

5. **Provider network must be owned by carrier with a current list of assigned providers submitted monthly to subscribers. This information is REQUIRED.**

   We fully own and operate the provider network through direct contracts with private practice doctors and retail optical providers.

In Washington and Oregon, we also accept network participation from providers via our contract agreement with Medical Eye Services of Oregon (MESO). This is not technically a lease agreement; the providers are contracted directly with MESO and agree to comply with the terms of our network participation.

We want to ensure you and your employees receive the most up-to-date provider information, so we recommend using our interactive voice response (IVR) system and **myuhcvision.com** website to obtain provider information, since these sources are continuously updated. We do not recommend the use of printed directories, as they are likely to be outdated by the time they are distributed.

If required, we can bulk-ship provider directories to you, but this typically incurs an additional cost. Please refer to the standard pricing guide attachment titled **Standard Print Pricing Sheet** in **Section 8** of this proposal for more information.

6. Carriers must have a credentialing process for adding new providers to their networks.

Confirmed. We have provided a description of our credentialing process below.

CREDENTIALING PROCESS OVERVIEW

To streamline our credentialing operations we use the Council for Affordable Quality Healthcare's Universal Provider Datasource® (UPD) to electronically collect provider information. The UPD service is the industry standard for collecting provider data used in credentialing. In 2013 more than 90 percent of our newly credentialed providers used UPD to give us their data. UPD aids providers and health plans by reducing paperwork and administrative costs, translating into cost savings, which are ultimately passed on to customers and consumers in the form of reduced premiums.

In addition to saving money, UPD enables us to reduce the time needed for credentialing, which means doctors joining our network are able to see our members more quickly, giving our members greater access to qualified doctors. Our average credentialing time in 2014 was 21 days.

We obtain a completed signed and dated application to begin the credentialing process. The following must be current upon final approval and forwarded to the Credentialing Verification Organization (CVO) for primary source verification:

- Provider's name, address and telephone number
- Current license, registration or certification
- Specialty board or other certification
- Details of any disciplinary actions by medical organizations and regulatory agencies
- A signed and dated attestation form
- Practice information, including call coverage
- Names of other states where the applicant is or has been licensed, registered or certified
- Professional and hospital affiliation
- Details of any felony or misdemeanor convictions
- Education, training and work history
- Drug Enforcement Agency (DEA) registration number and prescribing restrictions
- Amount of professional liability coverage and any malpractice history
- Type of affiliation requested (e.g., primary care, consulting specialists, ambulatory care, etc.)

We also obtain and retain on file the following information regarding facility provider credentials, when applicable:

- The Joint Commission's certification or certification from other accrediting agencies
- State licensure

- Medicare and Medicaid certification
- Evidence of current malpractice insurance

The credentialing coordinator prepares information on all providers who have completed the verification process and sends it to the credentialing committee for review and approval. When we accept an applicant, the recruiter sends a welcome letter within two weeks.

We recredential our providers at least once every three years. The CVO requests a recredentialing application and an updated signed attestation with accompanying documentation (e.g., copies of licenses; DEA/Controlled Dangerous Substance (CDS) identification; copy of the cover sheet from the provider's malpractice policy, etc.). The CVO verifies that information and checks Medicare/Medicaid and the state licensing board for sanctions against the provider's license. The recredentialing process also includes a review of the data from member complaints and results of quality reviews, when applicable.

We receive license sanction reports on a monthly basis from the CVO. Providers appearing on the report are reviewed to ensure they are able to remain in the network.

7. Enrollment must be open to active employees, employees on leave of absence and retirees. Enrollment shall include NO underwriting and NO pre-existing condition exclusions.

Confirmed. We agree to transfer coverage on a no loss/no gain basis. There are no pre-existing limitations under the vision plan. We agree to waive any actively-at-work and non-confinement requirements for participants.

8. Communicative materials, brochures, applications and provider directories must be approved by the City of Hollywood and made available upon request at no cost to the City of Hollywood or employees and retirees at the carrier's expense.

Confirmed. We are happy to provide samples of communications to the City of Hollywood for review and approval prior to distribution.

Post enrollment, certain member communications and messages may not be as readily available. These may include compliance communications, communications required to administer the employee's benefit plan, and confidential communications produced in accordance with a member's wellness program, care management program, clinical program or claims. In addition, the majority of these communications are not customizable due to legal and compliance requirements.

9. ID cards and coverage certificates must be mailed to the participant's home address two (2) weeks prior to the effective date of coverage at the carrier's expense.

ID cards will be mailed to the participants home address. Members can also print a personalized ID card from our member website, **myuhcvision.com.**

ID Cards Highlights
■ Personalized with name and ID number
■ Copayment and benefit information
■ Instructions for the provider
■ Can be printed at any time and as often as needed

The costs for mailing ID cards has been included; however, coverage certificates are not included in our costs. Please refer to the financial commentary for additional pricing information.

Please refer to the **ID Card Overview Flyer** in **Section 8** of this proposal. We have also provided a **Sample Certificate of Coverage** in **Section 8** of this proposal.

10. **Carrier must have a local account representative within a reasonable service area or fifty mile distance of the City of Hollywood. The local account representative will assist the group administrator with benefit and enrollment questions and concerns.**

Confirmed. The account management team (AMT) assigned to the City of Hollywood will be local.

11. **The carrier will be available to attend new employee orientations, health insurance committee meetings, annual enrollment meetings and benefit fairs as requested. Further, the carrier will provide supporting materials and reports for indicated meetings.**

Confirmed. We send knowledgeable representatives to answer questions and explain benefits at open enrollment meetings, health fairs or other events upon your request.

There is no limit to the number of meetings we will cover; however, meeting coverage is based on availability and the enrollment meeting guidelines listed below.

Number of employees – a minimum of 50 employees per site, per meeting is requested for presentations and Q&A sessions where employee attendance is mandatory

Notification time needed to prepare – a 10-day notice is standard for enrollment meetings. All other requests are based on availability.

ADDITIONAL RESOURCES

We also understand the challenge of communicating with employees in smaller locations and can offer the following at no additional cost:

- Teleconferences for smaller locations in which our representatives can answer employee questions and provide employees with information as they enroll for health care coverage
- Live webcast meetings
- Train-the-trainer sessions to prepare benefit professionals and managers to conduct enrollment meetings
- Articles for benefit/employee newsletters

HEALTH FAIRS

The account manager (AM) will meet with the City of Hollywood to create a customized open enrollment strategy. Customers may choose to host either enrollment meetings or question-and-answer sessions only, or they may opt to host a health fair. If a health fair is chosen, the AM will assist the City of Hollywood in selecting topics to focus on, e.g., wellness, member website, etc. Following creation of the strategy, the AM will suggest appropriate collateral materials, giveaways, etc.

ENROLLMENT COMMUNICATIONS

Since most individuals learn in different ways, we offer a variety of communications, such as the following:

- **Enrollment Form, Payroll Stuffers, Flyers.** Designed to inform your employees about the importance and features of our benefit plans, these materials are available in print, as well as electronically for posting to the City of Hollywood's Intranet site.

- **Audio-Visual Benefit Information on the Web.** These short, plan-specific presentations are accessible to employees and their dependents at a secure website 24 hours a day from any computer. No special software or technical knowledge is necessary. We provide you with a link and a scan code that you can embed into emails for your employees or place on your enrollment site. These presentations can even be accessed by employees on-the-go using a mobile device with scanning capabilities. Important communication materials can also be attached to the presentation for easy reference by employees.
- **Welcome Package.** The Welcome Package for new members describes the plan and how to locate a provider, check eligibility and plan details and access benefits.

By providing materials before enrollment, we focus on informing and engaging all of your employees—helping them to make the best decision to maximize coverage options. We focus on motivating the individual—one person at a time—because we've learned that personal relevance is the key to understanding the value of the plan(s).

We have provided sample enrollment communications in **Section 8** of this proposal. Please refer to the attachments **Vision Overview Brochure** and **Vision Welcome Guide.**

12. Customer Service - Carrier must provide a local service number, toll free service number, and a website for participants and providers.

We provide our members with a toll-free member service phone line. While we do not provide a local service number for members, the City of Hollywood will have access to local service numbers for your AMT. An overview of our websites for members and providers is detailed below.

MEMBER WEBSITE

Our member website, **myuhcvision.com**, offers a wide selection of services, anytime day or night, including the following:

- Print personalized ID cards (ID cards are not required for service)
- Locate providers by ZIP code, ZIP code with mileage radius, city and state, provider name or practice name
- Check claim status, program design, eligibility and copayment
- View, download and print Explanations of Benefits (EOB)
- Find answers to frequently asked questions, as well as links to other websites with information about vision care services and vision health
- Receive information about discounted laser eye surgery procedures, a laser surgeon provider locator and answers to frequently asked questions regarding laser eye surgery
- Receive information about exclusive pricing on hearing aids and how to obtain them
- Nominate a provider to join our network

PROVIDER WEBSITE

Our provider website offers a wide selection of services to our customers, members and providers, anytime day or night.

Vision providers have online access to:

- Check eligibility and plan benefit information

- Submit material orders to our manufacturing lab
- Review claim history
- Check order and claim status
- Review provider statements

13. Claims shall be processed within ten (10) days of receipt.

We confirm that we will process as follows:

- 90 percent of all clean claims will be processed within 10 business days of receipt.
- 90 percent of non-network clean claims will be processed within 10 business days of receipt.

In 2014, we processed 96.10 of clean non-network claims in 10 business days. We processed 96.70 percent of all clean claims in 10 business days. We processed 98.77 percent of all clean claims in 30 calendar days.

14. Carrier shall have a system to handle service issues within ten (10) business days. A quarterly report is required showing the nature and resolution of any service related concerns directed to the carrier or service representative.

We are committed to problem prevention. We provide simple tools and thorough training for your benefit representatives. We communicate proactively, clearly and frequently with you, and you will have ongoing telephone and email access to the Specialty Client Services team, a group of professionals dedicated to answering common day-to-day customer benefit questions. These individuals are empowered to research and independently resolve most questions and issues whenever possible.

In the event an issue escalated beyond the scope of the Specialty Client Services team should arise, the representative who answered the call would log the issue in our system, which immediately routes the item to the applicable functional area. A representative from the functional area would research the issue and provide a response to the Specialty Client Services team member who initially submitted the request. This individual would call you – or your appropriate representative – with the resolution. He or she may also involve the Strategic Account Executive as needed to assist with any complex or escalated issues.

MEMBER SERVICES

We value our members' opinions and strive to resolve questions at the first telephone call. Processes have been put in place at our member service center to document, address and quickly and effectively resolve member inquiries. As a result, in 2014, our first call resolution rate was 95.68 percent.

We document all inquiries in our automated, online system. Customer service representatives (CSRs) with additional specialized training address complex inquiries, problem resolution and claims adjustment. These CSRs are able to resolve many questions and concerns during the first point of contact with our members.

The system tracks issues that cannot be resolved during the first call. CSRs assign a main category based on the caller's issue For each of the main categories, the system calculates turnaround time frame based on the priority assigned (urgent or routine). Customer service managers and executive leaders monitor the turnaround time frames of open issues daily using reports generated by the inquiry system,

In the unusual case of verbal inquiry that is really a claim appeal or a complaint or grievance – for example, concerns about the quality of care received from a provider – the CSR advises the member to submit it in writing to the appeals and grievance department, so that the formal member complaint process can be initiated. Provider record requests are generated within 10 business days of receipt and our goal is to resolve all verbal and written complaints within 30 calendar days.

15. Carrier shall process a monthly electronic enrollment file in a format acceptable to the City of Hollywood or a website with plan administrator access for additions/ deletions of participants.

Confirmed. We typically receive eligibility data via the UnitedHealthcare Electronic Communication Gateway (ECG).

WHAT IS ECG?

Electronic Communication Gateway (ECG) is our standard electronic file format. It is a fast, efficient and secure way to transfer large and small amounts of data electronically to us. These files are pre-processed to ensure that all required fields have valid values. Some files go through a translation process where customer-supplied codes are translated into codes that facilitate processing. Once we have validated the data, we add or update the eligibility.

Let us make your job easier with our easy-to-use, online electronic eligibility management system, Employer eServices.

SUBMITTING ELIGIBILITY IS SO EASY

The first eligibility file sent to us is a full population file to establish your eligibility on our system.

Through our Employer eServices® electronic eligibility management system, ongoing eligibility files may be sent to our company using one of two methods:

Standard Method	Alternative Method
Each file includes only members who had a change (updates only) during the last reporting period. It includes member and dependent records that were newly enrolled, cancelled, had a change in eligibility or had a change in any field that is passed on the file.	**Each file includes the entire population that is covered (full population) regardless of whether any change occurred.**
The updates-only file is submitted daily with a monthly full population file submission. The full population file is used to compare current data against the data on our eligibility system.	**The full population file is submitted weekly.**

MANUAL/EMERGENCY UPDATES ARE DONE QUICKLY

Emergency criteria are defined as a member seeking services within 24 hours. You may enter manual or emergency updates via the Employer eServices website. To ensure that our eligibility information is updated and accurate at all times, it is important that you update your internal systems when submitting eligibility changes via Employer eServices in between electronic submissions.

ERROR REPORTING EASILY IDENTIFIES DISCREPANCIES

Error reports highlighting any discrepancies are generated on the Employer eServices website after each eligibility file has been processed. Other file statistics related to the additions, terminations and auto cancels are also available. Unless you submit daily update files, you will make error corrections via Employer eServices in addition to updating the source system to ensure immediate correction in our system.

16. Carrier shall provide a dedicated service representative to reconcile the monthly file, provide a discrepancy list, and issue a monthly invoice within five (5) business days of receipt of the enrollment file.

Not confirmed. We assign an electronic eligibility analyst that works with you to coordinate eligibility. Your eligibility analyst will also service other accounts.

Our system automatically generates file processing reports and sends an email after each file application, which includes a Web address where you can securely view or download the error reports.

Reports are available by file processing date and remain on the system for 30 days. You review all reports for accuracy and correct any discrepancies in the "Customer Corrections Required" report.

Where do we find our reports?	
Go to **employereservices.com**	
From the **Main Menu** click on the following reports: ■ Add Transactions ■ Change Transactions ■ No Change Transactions ■ Termination / Auto Cancel Transactions	From the **Processing Statistics** page click on the various report links: ■ Adds ■ Changes ■ No Changes ■ Terms

EXPLANATION OF REPORTS

PROCESSING STATISTICS

The Processing Statistics report contains the total number of enrollments, changes, cancellations and bypassed or rejected records that were processed.

ADD TRANSACTIONS

The Add Transactions report lists the individuals enrolled during the processing of the City of Hollywood's eligibility file.

CHANGE TRANSACTIONS

The Change Transactions report lists the individuals who had updates made to their eligibility.

NO CHANGE TRANSACTIONS

The No Change Transactions report lists the individuals without any changes made to their eligibility. No changes are usually the result of the application of your full population file. The system makes a comparison between records present on the full file with those records already in our eligibility system. The records identified as needing no update are classified as "No Change" and displayed within this report.

Terms Submitted/Auto-Cancel Transactions

This report lists coverage that was either terminated or had a change in date of termination with the electronic file application. The report is categorized by "Term Submitted" (termination date appeared on the file) and "Auto-Cancel" (individual did not appear on the City of Hollywood's full population file).

Customer Corrections Required

The Customer Corrections Required report lists each individual member record where an error occurred as a result of applying the recent eligibility file. It is very important that you review this report and determine how to correct the errors. You can correct errors during their next file application, or you can immediately correct them online via Employer eServices. You need to reflect any changes made via Employer eServices in your next electronic file to prevent the correction from being overlaid with the wrong data. Any errors that are not corrected may result in denied or incorrect claim payment for that member.

The Customer Corrections Required report informs you of a variety of errors. You can obtain a complete listing of the errors by using the "Help" feature on the Employer eServices website. We encourage you to contact your electronic eligibility analyst if you would like more specific information about the errors and how to correct them. Our staff is always here to help you.

SUBMISSION REQUIREMENTS

The Proposal shall be signed by a representative who is authorized to contractually bind the Proposer.

Each Proposal shall be prepared simply and economically, providing a straightforward, concise delineation of the Proposer's capabilities to satisfy the requirements of the RFP. The emphasis in each Proposal must be on completeness and clarity of content. In order to expedite the evaluation of Proposals, it is essential that Proposer follow the format and instructions contained herein. If the Proposer so wishes, the Proposal may be accompanied with brochures, promotional materials, or displays properly identified. However, Proposal Submission Requirements as listed herein must be followed. All Proposals must be submitted as specified on the Proposal pages which follow. Any attachments must be clearly identified.

The Proposal shall be considered an offer on the part of the Proposer, which offer shall be deemed accepted upon approval of the City Commission of the City of Hollywood, and in case of default the City of Hollywood reserves the right to accept or reject any or all Proposals, to waive irregularities and technicalities, and request new Proposals. The City also reserves the right to award any resulting agreement as it deems will best serve the interests of the City.

Noted.

FORMAT

1. Title Page

Show the Request for Proposal subject, the name of your firm, address, telephone number, name of contact person and date.

2. Table of Contents

Clearly identify the material by section and page number.

3. RFP Checklist

4. Letter of Transmittal

Limit to one (1) or two (2) printed pages.

a. Briefly state your firm's understanding of the work to be done and provide a positive commitment to perform the work.

UnitedHealthcare is committed to providing the City of Hollywood with a cost-effective and service oriented benefit plan solution. Our products and services are tailored to the needs of each of our customers based on their plan of benefits, employee population, location, and specific concerns and goals. We pride ourselves on an unwavering commitment to customer satisfaction and believe that as a valued customer you will find our product services provide a comprehensive enhancement to the services your employees are currently receiving. Our plan offers the best net value when both premiums and out-of-pocket costs are considered. We keep member costs low with innovative, cost-effective benefits. To deliver exceptional value, we offer cost-effective premiums, comprehensive benefits, outstanding network availability, reduced out-of-pocket expenses, extensive quality assurance and responsive, locally-based account management. The cornerstones of our philosophy include freedom of choice, focus on health and well-being, and freedom from conflicts of interest that can result from ties to one manufacturer, retail chain or provider group.

b. Give the names of the persons who will be authorized to make representations for your firm, their titles, addresses and telephone numbers.

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Email: **bpalme1@uhc.com**

5. Profile of Proposer

a. State whether your organization is national, regional or local.

National

b. State the location of the office from which your work is to be performed.

Your AMT will be located in Miramar, Florida within Broward County.

Our customer service center is located in San Antonio, Texas.

Vision claims are processed in International Falls, Minnesota. We issue EOBs and claims checks from Duncan, South Carolina.

c. Describe the firm, including the size, range of activities, etc. Particular emphasis should be given as to how the firm-wide experience and expertise in the area addressed by this Request for Proposal, will be brought to bear on the proposed work.

UnitedHealth Group is a diversified health and well-being company dedicated to making health care work better. Headquartered in Minneapolis, Minnesota, UnitedHealth Group uses two business platforms, UnitedHealthcare and Optum, to offer a broad spectrum of products and services. UnitedHealth Group currently employs approximately 168,000 people across all its businesses.

UnitedHealthcare is we are the largest commercial insurance company in the United States. UnitedHealthcare coordinates network-based health and well-being products and services that are innovative and affordable and that keep individuals involved in their own health and wellness. After all, informed consumers make better decisions, and that leads to lower medical costs. In addition to health benefit plans, UnitedHealthcare offers HSAs (health savings accounts) and HRAs (health reimbursement accounts), as well as specialty care programs such as vision, dental, life, disability and critical illness protection.

VISION CARE

Spectera, Inc. [or in certain circumstances United HealthCare Services, Inc.] is the affiliated legal entity that administers the vision business for UnitedHealthcare. UnitedHealthcare Insurance Company (UHIC) – or a state-specific affiliate – underwrites the fully insured plans. All these entities are ultimately owned by UnitedHealth Group. The vision organization was founded in 1964, incorporated in Maryland in 1981 and is certified to do business in all 50 states and the District of Columbia.

We own and operate two vision care operations: a vision laboratory that anchors our national lab network (which fills orders for network private practice providers), and two small retail chains, United Optical and Eye-Fit Vision Centers.

For nearly 50 years, we've been administering vision plans for groups of all types and sizes. Our customers include national and regional employers, multi-employer trust funds, insurance companies, third party administrators, associations, unions and state and local governments.

We are accustomed to serving the diverse needs of groups comprised of as little as one member all the way up to groups with hundreds of thousands of members.

We currently serve 522 customer groups with more than 3,000 members, and 88 of those are larger than 10,000 members. We have 680 public sector customers in our book of business.

J.D. Power 2014 Vision and Dental Plan Satisfaction Report[SM]	"Highest in Customer Satisfaction with Vision and Dental Plans"

UnitedHealthcare received the highest numerical score in the proprietary J.D. Power 2014 Vision and Dental Plan Satisfaction Reports[SM]. The reports are based on responses from 3,063 and 2,640 consumers, respectively, and measure opinions of consumers among four vision and seven dental plans. The reports measured vision and dental plan member satisfaction based on four key factors (in order of importance): coverage, cost, communications, customer service and reimbursements.

Proprietary study results are based on experiences and perceptions of consumers surveyed October-November 2014. Your experiences may vary. Visit **www.jdpower.com**.

d. Provide a list and description of similar municipal engagements satisfactorily performed within the past two (2) years. For each engagement listed, include the name, email, fax and telephone number of a representative for whom the engagement was undertaken who can verify satisfactory performance.

Please refer to the references provided in **Section 4** of this proposal.

e. Have you been involved in litigation within the last five (5) years or is there any pending litigation arising out of your performance?

UnitedHealth Group Incorporated affiliates comprise a large, complex organization, operating in a highly regulated environment, and engaged in myriad transactions out of which, from time to time, lawsuits have arisen. Specific details regarding these actions are considered proprietary; however, a summary of litigation is provided within UnitedHealth Group Incorporated's quarterly financial statements. (As an example, please refer to pp. 22 - 23 of the attached **2014 Q3 Financial Statement** for UnitedHealth Group Incorporated) included in **Section 8** of this proposal. None of these legal actions, either individually or collectively, would materially affect our ability to render services.

6. Summary of Proposer's Qualifications.

a. Identify the project manager and each individual who will work as part of the engagement. Include resumes for each person to be assigned. The resumes may be included as an appendix.

Melissa Wexler will be the assigned implementation manager assigned for the implementation for the City of Hollywood should we be selected as your vision carrier.

Melissa Wexler is an Ancillary Only Implementation Manager for UnitedHealthcare. She has been in this role since 2011 and with the company for fifteen years. Her book of business includes a significant amount of major, public sector and national accounts. As the “quarterback” for the implementation process, she oversees all functional processes and has successfully installed many complex dental and vision products. In her prior role with UnitedHealthcare, Melissa was a Medical Implementation Manager and worked with a local sales team. She also has a background in Human Resources administration. Her personal interests include working out, piano, and family vacations.

b. Describe the experience in conducting similar projects for each of the consultants assigned to the engagement. Describe the relevant educational background of each individual.

As stated above, detailed biographies of the account management team (AMT) members assigned to the City of Hollywood will be provided upon finalist notification.

All team members have between 6-20+ years of experience in selling, managing, servicing and/or renewing large groups – both public & private sector – for all lines of employee benefits. Resumes will be provided upon request.

c. Describe the organization of the proposed project team, detailing the level of involvement, field of expertise and estimated hours for each member of the team.

We have provided an overview of the AMT that will be assigned to the City of Hollywood. Detailed information and biographies of team members can be provided upon finalist notification.

We will provide a strong AMT to help you and your employees with day-to-day needs and long-term goals. We will assign a client manager (CM) as soon as the agreement is in place that has overall responsibility for our relationship with the City of Hollywood, including implementation and ongoing service. He or she is the day-to-day contact for the City of Hollywood. Our client managers have extensive experience with internal processes and systems and are readily available to meet your needs. By coordinating administrative functions through the AMT, we will provide you with specialized, cost-effective and highly responsive service solutions.

The strategic account executive (SAE) will lead the AMT, ensuring continuity between the sales process and implementation of your account. Specialists from multiple functional areas will make up the rest of the team. Team members will be well-trained in your benefit program and culture in order to give you complete, personalized service.

We will work with the City of Hollywood to ensure a working, customized partnership and that the plan is meeting your particular business and financial objectives. To that end, we will provide quarterly management reports, conduct regular performance assessments and we will work closely with you to propose solutions as new needs emerge.

The AMT delivers on our promise to maximize your investment. The team's top priority is building a working customized and successful partnership with you. Our team will work to understand your business objectives, and they have the expertise help you achieve those goals. Our partnership promise is to provide: effective coordination between multiple aspects of plan administration, ***with you always at the center***.

Please refer to the attachment **Sample Implementation Timeline** in **Section 8** of this proposal for a sample implementation plan, which provides an overview of the implementation tasks, responsibilities and timeframes. We meet with you to establish key milestones and target dates for completion at the start of the implementation phase.

d. Describe what municipal staff support you anticipate for the project.

Upon notification of sale, a detailed discussion of roles and responsibilities will take place with the City of Hollywood at the beginning of the process. We will work closely with the City of Hollywood to ensure your comfort level with implementation as well as all aspects of your plan.

7. Project understanding, proposed approach, and methodology.

Describe your approach to performing the contracted work. This should include the following points:

Type of services provided. Discuss your role and that of other parties involved in the data gathering, data analysis and recommendation process.

Discuss your project plan for this engagement outlining major tasks and responsibilities, time frames and staff assigned.

We have provided an overview of the account management team (AMT) that will be assigned to the City of Hollywood. Detailed information and biographies of team members can be provided upon finalist notification.

We will provide a strong AMT to help you and your employees with day-to-day needs and long-term goals. We will assign a client manager (CM) as soon as the agreement is in place that has overall responsibility for our relationship with the City of Hollywood, including implementation and ongoing service. He or she is the day-to-day contact for the City of Hollywood. Our client managers have extensive experience with internal processes and systems and are readily available to meet your needs. By coordinating administrative functions through the AMT, we will provide you with specialized, cost-effective and highly responsive service solutions.

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Our account managers, CSRs and implementation teams, are trained, experienced and qualified to handle voluntary enrollment and implementation. You will have the support of an enrollment consultant on our enrollment support team to consult on the enrollment strategy and coordinate aspects of the enrollment plan.

Please refer to the attachment **Sample Implementation Timeline** in **Section 8** of this proposal for a sample implementation plan, which provides an overview of the implementation tasks, responsibilities and timeframes. We meet with you to establish key milestones and target dates for completion at the start of the implementation phase.

8. Summary of the Proposer's Fee Statement.

The Proposal will show the fee schedule. Express your fee for the components of the work shown in scope of service and include a chart of the rates which ties the project plan. Additionally, indicate your expectations concerning reimbursement for travel, per diem expenses, photocopying, telephone lines or other incidental expenses, if applicable. If additional work is required beyond the scope of this contract, how would those services be billed? This may include additional presentations or follow-up as requested.

Plan Cost

- **Please include information regarding plan cost to employees based upon benefits indicated in the request.**

Single	Please refer to financial commentary.	per month
Individual plus one	Please refer to financial commentary.	per month
Family	Please refer to financial commentary.	per month

- **Schedule of Benefits**

  Please refer to financial commentary.

- **Location of Support**

  Your AMT will be located in Miramar, Florida.

  Our customer service center is located in San Antonio, Texas.

Vision claims are processed in International Falls, Minnesota. We issue EOBs and claims checks from Duncan, South Carolina.

- **Assigned Staff**

  As indicated above, Your AMT will be located in Miramar, Florida.

  Our customer service center is located in San Antonio, Texas.

  Vision claims are processed in International Falls, Minnesota. We issue EOBs and claims checks from Duncan, South Carolina.

9. Project time schedule, if applicable.

Provide a detailed time schedule for this project.

Please refer to the attachment **Sample Implementation Timeline** in **Section 8** of this proposal for a sample implementation plan, which provides an overview of the implementation tasks, responsibilities and timeframes. We meet with you to establish key milestones and target dates for completion at the start of the implementation phase.

NOTE: It is the responsibility of each Proposer to redact all financial information (i.e., social security numbers and bank account numbers) from your RFP prior to submittal, which are exempt from the Florida Statutes Chapter 119, (Public Records Law).

Noted.

OTHER CONSIDERATIONS

1. **The City reserves the right to approve substitutions for assigned personnel proposed for this engagement. Substitutions may be allowed for staff turnover, sickness or other emergency situations.**

   Confirmed.

2. **All contact for information regarding the Proposal must be addressed to the City of Hollywood's Procurement Services Division. Over the course of this RFP process, related contact with City Staff by a respondent or their agent, other than as part of the evaluation process or for clarification purposes, will be grounds for automatic disqualification of that vendor.**

   Each Proposer shall examine all Proposal Documents and judge for themselves all matters relating to the adequacy and accuracy of the documents. If the Proposer is of the opinion that any part(s) of the Proposal Document is incorrect or obscure, or that additional information is needed, he should request such information or clarification from the Procurement Services Division in order that appropriate addenda may be issued, if necessary, to all prospective Proposers.

   Noted.

3. **No oral change or interpretation of the provisions contained in this Request for Proposal is valid whether issued at a pre-proposal conference or otherwise. Written addenda will be issued when changes, clarifications, or amendments to Proposal Documents are deemed necessary. The issuance of a written addendum is the only official method whereby interpretation, clarification or additional information can be given.**

   Noted.

4. **All materials submitted in response to the RFP become the property of the City of Hollywood and will be returned only at the option of the City. The City has the right to use any or all ideas presented in any response to the RFP whether amended or not and selection or rejection of the Proposal does not affect this right, provided however, that any Proposal that has been submitted to the City Clerk's Office may be withdrawn prior to Proposal opening time stated herein, upon proper identification and signature releasing Proposal Documents back to Proposer.**

   Noted. This proposal is provided in response to a request to bid; information included in the proposal is to be used only in that context.

5. **After initial review of the Proposals, the City may invite consultants for an interview to discuss the Proposal and meet its representatives, particularly key personnel who would be assigned to the project. It is understood that the City shall incur no costs as a result of this interview, nor bear any obligation in further consideration of the Proposal.**

   Confirmed.

6. **Copies of Proposals submitted may not be viewed until thirty (30) days after RFP opening date.**

   Noted.

7. **The City reserves the right to determine, at its sole discretion, whether any aspect of a Proposal satisfies the criteria established in this Request for Proposals. The City further reserves the right to negotiate with any person or firm submitting**

   Proposals and reserves the right to reject any or all Proposals with or without cause. The City also reserves the right to waive minor technical defects in a Proposal. In the event that this Request for Proposals is withdrawn by the City for any reason, the City shall have no liability to any applicant for any costs or expenses incurred in connection with this Request for Proposals or otherwise. All such expenses incurred in the preparation of a Proposal shall be borne by the Proposer.

   Failure or refusal of the successful Proposer to execute a contract within thirty (30) days after award shall constitute a default. Any such Proposer shall not assign, transfer, convey or otherwise dispose of any or all of its rights, title or interest therein, or its power to execute such contract to any person or firm without prior written consent of the City.

   Noted.

8. **Vendors conducting business with the City of Hollywood whose business is located in the State of Florida, should be properly registered with the State of Florida Division of Corporations. Registration is a requirement to do business with the City of Hollywood, however, the State of Florida Division of Corporations registration process is not administered by the City. Please visit http://sunbiz.org/ to register your company or for further question regarding registration.**

   Confirmed.

9. **The Immigration and Nationality Act prohibits (i) the employment of an unauthorized alien when the employer knows the individual is an unauthorized alien and (ii) the employment of an individual without complying with the requirements of the federal employment verification system. If a contractor commits either of these violations, such violation shall be cause for unilateral cancellation of the contract.**

   We confirm that our organization is in compliance with the Immigration and Reform Control Act of 1986. We generally request 60-days' prior written notice in the event of contract termination.

The following trademarks and service marks are owned by UnitedHealth Group Incorporated:

Access for Life®	Impact Pro™	PlanBien℠	UnitedHealth Passport®
Advocate4Me™	LifeEra®	Plan Cost Estimator™	UnitedHealth Premium®
Affordability Solutions Index™	myuhc.com®	Practice Matters®	UnitedHealth Wellness®
Algorithms for Effective Reporting and Treatment (ALERT®)	National Benefit Resources®	QuitPower®	UnitedHealthcare Catalyst℠
American Chiropractic Network (ACN Group®)	NurseLine℠	Rewards for Action®	UnitedHealthcare® Community & State
Aperture®	OnePay Plan℠	SimplyAccountable®	UnitedHealthcare Core℠
Care Coordination℠	OnlinEnroll℠	SimplyEngaged®	UnitedHealthcare® Employer & Individual
Care24℠	Optum® OptumHealth℠	Spectera®	UnitedHealthcare® Global
Consumer Activation Index™	OptumHealth Bank℠	Symmetry EBM Connect®	UnitedHealthcare® Group Medicare Advantage
Definity® Definity Health®	OptumHealth Financial Services℠	Symmetry Episode Treatment Groups® (ETG®)	UnitedHealthcare® Medicare & Retirement
EBM Connect®	OptumInsight™	Symmetry Procedure Episode Group® (PEG®)	UnitedHealthcare Navigate℠
Employer eServices®	OptumizeMe℠	Taking Care®	UnitedHealthcare Navigate Balanced℠
eSync Platform℠ eSync℠	OptumRx™	Total Affordability Management℠	UnitedHealthcare Navigate Plus℠
Flex Share Rewards®	Orthopedic Decision Support℠	ubhonline®	UnitedHealthcare Online®
GeoNetworks®	ParentSteps®	United eServices®	UnitedHealthcare Personal Care Plus®
Golden Rule®	Parallax *i*®	UnitedHealth Allies®	UnitedHealthcare® Pharmacy
Healing health care. Together.®	Passport Connect®	UnitedHealth Basics®	UnitedHealthcare Total Choice℠
Health A to Z℠	Performance Rewards℠	UnitedHealth Continuity℠	UnitedRx National℠
HealthForums.com®	Personalization is the heart of health care℠	UnitedHealth Group®	View360™
hub℠ hub magazine℠	PHCS®	UnitedHealth International®	Vital Measures®

The following trademarks are owned by third parties not affiliated with UnitedHealth Group Incorporated and are used with permission:

435 Project®	Champion®	iPhone® (iOS)	Nordic Track®
AARP®	etalk Advisor™ etalk Recorder™	Jenny Craig®	Qfiniti™
Adobe®	Facebook®	Knowlagent®	TelePAID®
Android™	Healthwise®	LexisNexis®	TotalView®
BeniComp®	HEDIS®	MasterCard®	Windows®Phone 7
CAHPS®	IEX®	Milliman Care Guidelines®	

A Benefits Proposal for

City of Hollywood

Issued on: February 16, 2015

UnitedHealthcare®

Why Choose UnitedHealthcare?

Cost Savings

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

Convenience

The advantages available when purchasing multiple products include:

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

Better Health

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

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

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

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

About UnitedHealth Group®

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

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

City of Hollywood | Vision Proposal
Effective Date: April 1, 2015

Vision Services		NEW_1283778_V1 Triple Option		NEW_1283779_V1 Triple Option	
Legal Entity		UnitedHealthcare Insurance Company Primary Plan		UnitedHealthcare Insurance Company Primary Plan	
		In Network	**Out of Network**	**In Network**	**Out of Network**
Plan Options					
Contribution		Voluntary		Voluntary	
Product Type		Exam with Materials		Exam with Materials	
Network Type		Full Network		Full Network	
Exam Co-pay		$10	Not Applicable	$10	Not Applicable
Material Co-pay (Frames/Spectacle Lenses or Contact Lenses)		$25	Not Applicable	$20	Not Applicable
Service Frequency					
Exams/ Lenses/ Frames/Contacts		12/12/24/12		12/12/24/12	
Eye Examination					
Exam		100%	Up to $40	100%	Up to $40
Lenses					
Single Vision		100%	Up to $40	100%	Up to $40
Lined Bifocal		100%	Up to $60	100%	Up to $60
Lined Trifocal		100%	Up to $80	100%	Up to $80
Lenticular		100%	Up to $80	100%	Up to $80
Frames					
Retail Frame Allowance		Up to $100	Up to $45	Up to $130	Up to $45
Discount on Frame Overage at participating providers		30%	Not Applicable	30%	Not Applicable
Elective Contact Lenses					
Covered Selection Contacts		Up to 4 boxes	Up to $100	Up to 4 boxes	Up to $130
Non-Selection Contacts		Up to $100	Up to $100	Up to $130	Up to $130
Necessary Contact Lenses		100%	Up to $210	100%	Up to $210
Lens Options					
Covered-in-full Lens Options		Gradient Tint ;Polycarbonate Lenses (Multi Focal) ;Polycarbonate Lenses (Single Vision) ;Solid Tint ;Standard Scratch-Resistant Coating	Not Applicable	Gradient Tint ;Polycarbonate Lenses (Multi Focal) ;Polycarbonate Lenses (Single Vision) ;Solid Tint ;Standard Scratch-Resistant Coating	Not Applicable
Non-covered Lens Options		Price Protection available for non-covered lens options ranging from 20-60% off retail pricing at participating providers.			
Value Services					
Laser Vision Discount		UnitedHealthcare is proud to add value to your vision care program by offering access to discounted laser vision correction procedures through Laser Vision Network of America (LVNA). Members receive a discount of 15% off standard prices or 5% off promotional prices with any in-network surgeon.			
Assumed Enrollment and Rates					
Employee		32	$4.83	45	$6.22
Employee + Spouse		15	$8.98	16	$11.49
Employee + Child(ren)		10	$10.53	9	$13.48
Employee + Family		20	$14.53	13	$18.49
		77		83	
Monthly Premium		**$685.16**		**$825.43**	
Annual Premium		**$8,221.92**		**$9,905.16**	
Participation Requirements		No Participation Requirement		No Participation Requirement	
Dependent Children Coverage		To Age 26		To Age 26	
Contract Basis		Fully Insured		Fully Insured	
Exclusions and Limitations		Standard		Standard	
Broker Commissions		0%		0%	
Rate Guarantee		36 Months		36 Months	

Vision Services	**NEW_1283786_V1** **Triple Option**	
Legal Entity	**UnitedHealthcare Insurance Company** **Primary Plan**	
	In Network / **Out of Network**	
Plan Options		
Contribution	Voluntary	
Product Type	Exam with Materials	
Network Type	Full Network	
Exam Co-pay	$10 / Not Applicable	
Material Co-pay (Frames/Spectacle Lenses or Contact Lenses)	$10 / Not Applicable	
Service Frequency		
Exams/ Lenses/ Frames/Contacts	12/12/24/12	
Eye Examination		
Exam	100% / Up to $40	
Lenses		
Single Vision	100% / Up to $40	
Lined Bifocal	100% / Up to $60	
Lined Trifocal	100% / Up to $80	
Lenticular	100% / Up to $80	
Frames		
Retail Frame Allowance	Up to $150 / Up to $45	
Discount on Frame Overage at participating providers	30% / Not Applicable	
Elective Contact Lenses		
Covered Selection Contacts	Up to 6 boxes / Up to $150	
Non-Selection Contacts	Up to $150 / Up to $150	
Necessary Contact Lenses	100% / Up to $210	
Lens Options		
Covered-in-full Lens Options	Gradient Tint ;Polycarbonate Lenses (Multi Focal) ;Polycarbonate Lenses (Single Vision) ;Solid Tint ;Standard Anti-Reflective Coating ;Standard Progressive Lenses ;Standard Scratch-Resistant Coating / Not Applicable	
Non-covered Lens Options	Price Protection available for non-covered lens options ranging from 20-60% off retail pricing at participating providers.	
Value Services		
Laser Vision Discount	UnitedHealthcare is proud to add value to your vision care program by offering access to discounted laser vision correction procedures through Laser Vision Network of America (LVNA). Members receive a discount of 15% off standard prices or 5% off promotional prices with any in-network surgeon.	
Assumed Enrollment and Rates		
Employee	167 / $8.46	
Employee + Spouse	110 / $15.62	
Employee + Child(ren)	66 / $18.33	
Employee + Family	111 / $25.12	
	454	
Monthly Premium	**$7,129.12**	
Annual Premium	**$85,549.44**	
Participation Requirements	No Participation Requirement	
Dependent Children Coverage	To Age 26	
Contract Basis	Fully Insured	
Exclusions and Limitations	Standard	
Broker Commissions	0%	
Rate Guarantee	36 Months	

Lens Option Price Protection

The list below outlines the maximum out of pocket charge a member may pay for particular non-covered lens options in-network, which reflect discounts of 20 to 60% of retail charges. In some cases members may pay less!

Type	Cost
Polycarbonate	$30
Photochromic	$65
Scratch Warranty	$10
Edge Coat (Polished Edges)	$13
High Index 1.60-1.67	$60
Solid Tint	$13
Gradient Tint	$15
UV Coating	$16
Standard Anti-Reflective Coating	$40
Premium Anti-Reflective Coating	$80
Platinum Anti-Reflective Coating	$90
Standard Progressive	$70
Deluxe Progressive	$110
Premium Progressive	$150
Platinum Progressive	$250

Prices reflected are subject to change.

General Assumptions

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

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

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

- Assumed contract situs is Florida.

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

- Employer's assumed primary business is classified as 9111 SIC Code.

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

Vision Assumptions

Rates are valid for 90 days from 02/11/2015 or 04/01/2015, whichever is sooner.

The Dental and/or Vision premium includes expenses related to state & federal taxes, fees, and assessments. It may also include additional new taxes, fees and assessments from the Affordable Care Act.

Quote assumes a complete product replacement.

Rates listed above are not included in quoted Medical rates (if applicable).

Rates listed above assume plan designs quoted. Rates may change, if plan design changes.

We reserve the right to change rates and/or plan provisions if the number of lives enrolled in any plan option offered in dual or triple choice Program (ex: labeled either as Option A, Option B or Option C), changes by more than 10% before, on, or after the effective date listed above.

The proposal assumes a dual option. This means the group can select any plan labeled as an Option (ex: Option A alongside any plan labeled as Option B or Option C) for purchase. These plans are mutually exclusive and cannot be combined in any order other than as identified above.

The quote includes ID cards mailed to the employee's home address.

Please note that the summary of benefits in this document provides a brief description of coverage. State mandates may preclude certain benefit plan design features. This is not a policy, certificate of insurance or coverage document. For complete details on coverage, exclusions, limitations and the terms under which coverage may continue, please contact your sales representative.

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

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

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

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

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

Issue Date: January 30, 2015

City of Hollywood, Florida
Solicitation #RFP-4448-15-RD

ACKNOWLEDGMENT AND SIGNATURE PAGE

This form must be completed and submitted by the date and the time of bid opening.

Legal Company Name (include d/b/a if applicable): UnitedHealthcare Insurance Company Federal Tax Identification Number: 36-2739571

If Corporation - Date Incorporated/Organized: March 24, 1972

State Incorporated/Organized: Connecticut

Company Operating Address: 185 Asylum St

City Hartford State CT Zip Code 06103

Remittance Address (if different from ordering address): _____

City _____ State _____ Zip Code _____

Company Contact Person: Angelo Golemi Email Address: angelo_golemi@uhc.com

Phone Number (include area code): 954-378-0572 Fax Number (include area code): 877-332-1831

Company's Internet Web Address: www.unitedhealthgroup.com

IT IS HEREBY CERTIFIED AND AFFIRMED THAT THE BIDDER/PROPOSER CERTIFIES ACCEPTANCE OF THE TERMS, CONDITIONS, SPECIFICATIONS, ATTACHMENTS AND ANY ADDENDA. THE BIDDER/PROPOSER SHALL ACCEPT ANY AWARDS MADE AS A RESULT OF THIS SOLICITATION. BIDDER/PROPOSER FURTHER AGREES THAT PRICES QUOTED WILL REMAIN FIXED FOR THE PERIOD OF TIME STATED IN THE SOLICITATION.

_____ 2/12/15

Bidder/Proposer's Authorized Representative's Signature: Date

Type or Print Name: Philip R. Kaufman, President

THE EXECUTION OF THIS FORM CONSTITUTES THE UNEQUIVOCAL OFFER OF BIDDER/PROPOSER TO BE BOUND BY THE TERMS OF ITS PROPOSAL. FAILURE TO SIGN THIS SOLICITATION WHERE INDICATED BY AN AUTHORIZED REPRESENTATIVE SHALL RENDER THE BID/PROPOSAL NON-RESPONSIVE. THE CITY MAY, HOWEVER, IN ITS SOLE DISCRETION, ACCEPT ANY BID/PROPOSAL THAT INCLUDES AN EXECUTED DOCUMENT WHICH UNEQUIVOCALLY BINDS THE BIDDER/PROPOSER TO THE TERMS OF ITS OFFER.

ANY EXCEPTION, CHANGES OR ALTERATIONS TO THE GENERAL TERMS AND CONDITIONS, HOLD HARMLESS/INDEMNITY DOCUMENT OR OTHER REQUIRED FORMS MAY RESULT IN THE BID/PROPOSAL BE DEEMED NON-RESPONSIVE AND DISQUALIFIED FORM THE AWARD PROCESS.

Issue Date: January 30, 2015

City of Hollywood, Florida
Solicitation #RFP-4448-15-RD

HOLD HARMLESS AND INDEMNITY CLAUSE

UnitedHealthcare Insurance Company and Philip R. Kaufman
(Company Name and Authorized Representative's Name)

, the contractor, shall indemnify, defend and hold harmless the City of Hollywood, its elected and appointed officials, employees and agents for any and all suits, actions, legal or administrative proceedings, claims, damage, liabilities, interest, attorney's fees, costs of any kind whether arising prior to the start of activities or following the completion or acceptance and in any manner directly or indirectly caused, occasioned or contributed to in whole or in part by reason of any act, error or omission, fault or negligence whether active or passive by the contractor, or anyone acting under its direction, control, or on its behalf in connection with or incident to its performance of the contract.

SIGNATURE

Philip R. Kaufman
PRINTED NAME

UnitedHealthcare Insurance Company
COMPANY OF NAME

2/12/15
DATE

Failure to sign or changes to this page shall render your bid non-responsive.

Note: All fully insured group policies are subject to regulation by the Florida Office of Insurance Regulation (OIR). Consequently, our group policies must be filed and approved by the FL OIR, before they can be sold in Florida. To accommodate the individual requirements of each prospective customer, we leave certain provisions bracketed (i.e., open) in our filed policies. However, there is no hold harmless provision in the insured contract and it is not one of those bracketed items. Since we assume the risk under an insurance contract, we do accept liability for those acts that arise out of our performance under the contract, to the extent that the customer does not contribute to the problem in some way.

Issue Date: January 30, 2015

City of Hollywood, Florida
Solicitation #RFP-4448-15-RD

NONCOLLUSION AFFIDAVIT

STATE OF: Minnesota

COUNTY OF: Hennepin, being first duly sworn, deposes and says that:

(1) He/she is President, SB of UnitedHealthcare Insurance Company, the Bidder that has submitted the attached Bid.

(2) He/she has been fully informed regarding the preparation and contents of the attached Bid and of all pertinent circumstances regarding such Bid;

(3) Such Bid is genuine and is not a collusion or sham Bid;

(4) Neither the said Bidder nor any of its officers, partners, owners, agents, representatives, employees or parties in interest, including this affiant has in any way colluded, conspired, connived or agreed, directly or indirectly with any other Bidder, firm or person to submit a collusive or sham Bid in connection with the contractor for which the attached Bid has been submitted or to refrain from bidding in connection with such contract, or has in any manner, directly or indirectly, sought by agreement or collusion or communication or conference with any other Bidder, firm or person to fix the price or prices, profit or cost element of the Bid price or the Bid price of any other Bidder, or to secure an advantage against the City of Hollywood or any person interested in the proposed Contract; and

(5) The price or prices quoted in the attached Bid are fair and proper and are not tainted by any collusion, conspiracy, connivance or unlawful agreement on the part of the Bidder or any of its agents, representatives, owners, employees, or parties in interest, including this affiant.

(SIGNED) _____ President, Specialty Benefits
Title

TRACY LYNN RIDOUT
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2017

Tracy Lynn Ridout 2/12/15

Failure to sign or changes to this page shall render your bid non-responsive.

City of Hollywood, Florida
Issue Date: January 30, 2015 Solicitation #RFP-4448-15-RD

SWORN STATEMENT PURSUANT TO SECTION 287.133 (3) (a) FLORIDA STATUTES ON PUBLIC ENTITY CRIMES

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS

1. This form statement is submitted to City of Hollywood, FL
by Philip R. Kaufman for UnitedHealthcare Insurance Company
(Print individual's name and title) (Print name of entity submitting sworn statement)
whose business address is 185 Asylum St, Hartford, CT 06103
and if applicable its Federal Employer Identification Number (FEIN) is 36-2739571 If the entity has no FEIN, include the Social Security Number of the individual signing this sworn statement.

2. I understand that "public entity crime," as defined in paragraph 287.133(1)(g), Florida Statues, means a violation of any state or federal law by a person with respect to and directly related to the transaction of business with any public entity or with an agency or political subdivision of any other state or with the United States, including, but not limited to, any bid, proposal, reply, or contract for goods or services, any lease for real property, or any contract for the construction or repair of a public building or public work, involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misinterpretation.

3. I understand that "convicted" or "conviction" as defined in Paragraph 287.133(1)(b), Florida Statutes, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in an federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, nonjury trial, or entry of a plea of guilty or nolo contendere.

4. I understand that "Affiliate," as defined in paragraph 287.133(1)(a), Florida Statutes, means:

1. A predecessor or successor of a person convicted of a public entity crime, or
2. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

5 I understand that "person," as defined in Paragraph 287.133(1)(e), Florida Statues, means any natural person or any entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "person" includes those officers, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. (Please indicate which statement applies.)

__X__ Neither the entity submitting sworn statement, nor any of its officers, director, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an

affiliate of the entity has been charged with and convicted of a public entity crime, but the Final Order entered by the Hearing Officer in a subsequent proceeding before a Hearing Officer of the State of the State of Florida, Division of Administrative Hearings, determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list. (attach a copy of the Final Order).

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH 1 (ONE) ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THAT PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017 FLORIDA STATUTES FOR A CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

PM

(Signature)

Sworn to and subscribed before me this 12 day of February, 2015.

Personally known employer

Or produced identification Drivers License Notary Public-State of Minnesota

Stamp my commission expires January 31, 2017
(Type of identification)

Tracy Lynn Ridout
(Printed, typed or stamped commissioned name of notary public)

TRACY LYNN RIDOUT
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2017

Failure to sign or changes to this page shall render your bid non-responsive.

Issue Date: January 30, 2015

City of Hollywood, Florida
Solicitation #RFP-4448-15-RD

CERTIFICATIONS REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The applicant certifies that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, sentenced to a denial of Federal benefits by a State or Federal court, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) Have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction, violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) Have not within a three-year period preceding this application had one or more public transactions (Federal, State, or local) terminated for cause or default.

Applicant Name and Address:

Philip R. Kaufman

UnitedHealthcare Insurance Company

185 Asylum St., Hartford, CT 06103

Application Number and/or Project Name:

RFP-4448-15 Voluntary Vision Insurance

Applicant IRS/Vendor Number: FEID 36-2739571

Type/Print Name and Title of Authorized Representative:

Philip R.Kaufman, President

Signature: _____ Date: 2/2/15

Failure to sign or changes to this page shall render your bid non-responsive.

Issue Date: January 30, 2015

City of Hollywood, Florida
Solicitation #RFP-4448-15-RD

DRUG-FREE WORKPLACE PROGRAM

IDENTICAL TIE BIDS - Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedures for processing tie bids will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.
2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
3. Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).
4. In the statement specified in subsection (1), notify the employee that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.
5. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program (if such is available in the employee's community) by, any employee who is so convicted.
6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of these requirements.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

VENDOR'S SIGNATURE	Philip R. Kaufman PRINTED NAME

UnitedHealthcare Insurance Company
NAME OF COMPANY

Deviation for 5: Depending on the circumstances, an employee's return to work, reinstatement, and/or continued employment may be conditioned on the employee's successful participation in and/or completion of any and all evaluations, counseling, treatments, and rehabilitation programs, passing of return-to-duty and follow-up tests, and/or other appropriate conditions as determined by UnitedHealth Group.

Issue Date: January 30, 2015

City of Hollywood, Florida
Solicitation #RFP-4448-15-RD

SOLICITATION, GIVING, AND ACCEPTANCE OF GIFTS POLICY

Florida Statute 112.313 prohibits the solicitation or acceptance of Gifts. - "No Public officer, employee of an agency, local government attorney, or candidate for nomination or election shall solicit or accept anything of value to the recipient, including a gift, loan, reward, promise of future employment, favor, or service, based upon any understanding that the vote, official action, or judgment of the public officer, employee, local government attorney, or candidate would be influenced thereby.". The term "public officer" includes "any person elected or appointed to hold office in any agency, including any person serving on an advisory body."

The City of Hollywood policy prohibits all public officers, elected or appointed, all employees, and their families from accepting any gifts of any value, either directly or indirectly, from any contractor, vendor, consultant, or business with whom the City does business.

The State of Florida definition of "gifts" includes the following:

Real property or its use,
Tangible or intangible personal property, or its use,
A preferential rate or terms on a debt, loan, goods, or services,
Forgiveness of indebtedness,
Transportation, lodging, or parking,
Food or beverage,
Membership dues,
Entrance fees, admission fees, or tickets to events, performances, or facilities,
Plants, flowers or floral arrangements
Services provided by persons pursuant to a professional license or certificate.
Other personal services for which a fee is normally charged by the person providing the services.
Any other similar service or thing having an attributable value not already provided for in this section.

Any contractor, vendor, consultant, or business found to have given a gift to a public officer or employee, or his/her family, will be subject to dismissal or revocation of contract.

As the person authorized to sign the statement, I certify that this firm will comply fully with this policy.

SIGNATURE	Philip R. Kaufman PRINTED NAME
UnitedHealthcare Insurance Company NAME OF COMPANY	President TITLE

Failure to sign this page shall render your bid non-responsive.

DELEGATION OF AUTHORITY
FROM
UNITED HEALTHCARE INSURANCE COMPANY

1. It is hereby confirmed and approved that individual members of the Specialized Care Services business segment of UnitedHealth Group Incorporated are authorized to legally bind United HealthCare Insurance Company NAIC No 79413 ("UHIC") so long as such members are acting within the limits imposed by the Specialized Care Services delegation of authority policies and principles as amended from time to time.

2. Without limiting the generality of the foregoing, and to enable certain persons to efficiently demonstrate their authority to legally bind UHIC, it is hereby confirmed and approved that the specified officers of the companies set forth below are authorized to legally bind UHIC so long as such members are acting within the limits imposed by the Specialized Care Services delegation of authority policies and principles as amended from time to time:

Specialized Care Services, Inc.
Chief Executive Officer
President
Chief Financial Officer
General Counsel
CEO, Unimerica Workplace Benefits
VP, Operations, Unimerica Workplace Benefits
Deputy General Counsel

United Behavioral Health
Chief Executive Officer
President
Chief Operating Officer
Chief Financial Officer
Executive Vice President

Dental Benefit Providers, Inc.
Chief Executive Officer
President
Chief Operating Officer
Chief Financial Officer

United Resource Networks
Chief Executive Officer
President
Chief Operating Officer
Chief Financial Officer

Spectera, Inc.
Chief Executive Officer
President
Chief Operating Officer
Chief Financial Officer

National Benefit Resources, Inc.
Chief Executive Officer
President
Chief Operating Officer
Chief Financial Officer

Disability Consulting Group, LLC
Chief Executive Officer
President
Chief Operating Officer
Chief Financial Officer

Special Risk International, Inc.
Chief Executive Officer
President
Chief Operating Officer
Chief Financial Officer

Dated: January 15, 2004

UNITED HEALTHCARE INSURANCE COMPANY

By: _____
Ronald B. Colby
President and Chief Executive Officer

City of Hollywood, Florida
Issue Date: January 30, 2015 Solicitation #RFP-4448-15-RD

REFERENCE QUESTIONNAIRE

It is the responsibility of the contractor/vendor to provide a minimum of three (3) similar type references using this form and to provide this information with your submission. Failure to do so may result in the rejection of your submission.

Giving reference for: UNITEDHEALTHCARE VISION

Firm giving Reference: BROWARD COUNTY BOCC

Address: 115 S. ANDREWS AVE, #514, FORT LAUDERDALE, FL 33301

Phone: 954-357-6720

Fax: 954-728-2778

Email: lmorrison@broward.org

1. **Q:** What was the dollar value of the contract?
   A: Approximately $2 million over a 5 year contract period.

2. Have there been any change orders, and if so, how many?
   A: No

3. **Q:** Did they perform on a timely basis as required by the agreement?
   A: Yes, they have met their performance guarantees

4. **Q:** Was the project manager easy to get in contact with?
   A: Yes, Liz Colmain and Arelis Marcalle were very responsive to our calls and emails.

5. **Q:** Would you use them again?
   A: Yes, based on selection by an internal Evaluation Committee through the RFP process.

6. **Q:** Overall, what would you rate their performance? (Scale from 1-5)

   A: ☐xxx**5** *Excellent* ☐**4** *Good* ☐**3** *Fair* ☐ **2** *Poor* ☐**1** *Unacceptable*

7. **Q:** Is there anything else we should know, that we have not asked?
   A: UnitedHealthcare replaced Humana as our vision carrier effective 1/1/12. Their rates were lower than our current rates and provided additional services. We receive very few complaints from employees and enrollment remains steady even though it is 100% paid by the employee.

The undersigned does hereby certify that the foregoing and subsequent statements are true and correct and are made independently, free from vendor interference/collusion.

Name: Lisa Morrison Title Benefits Manager

Signature: Lisa C Morrison Date: 02/09/15

City of Hollywood, Florida
Issue Date: January 30, 2015 Solicitation #RFP-4448-15-RD

REFERENCE QUESTIONNAIRE

It is the responsibility of the contractor/vendor to provide a minimum of three (3) similar type references using this form and to provide this information with your submission. Failure to do so may result in the rejection of your submission.

Giving reference for: UnitedHealthcare

Firm giving Reference: City of Fort Lauderdale, Guy Hine, Risk Manager

Address: 100 North Andrews Avenue, Fort Lauderdale, FL 33301

Phone: (954) 828-5494

Fax: (954) 828-5439

Email: GHINE@FORTLAUDERDALE.GOV

1. **Q:** What was the dollar value of the contract?
   A: $136,799 annually.

2. Have there been any change orders, and if so, how many?
   A: No change orders.

3. **Q:** Did they perform on a timely basis as required by the agreement?
   A: Yes

4. **Q:** Was the project manager easy to get in contact with?
   A: Yes

5. **Q:** Would you use them again?
   A: Yes

6. **Q:** Overall, what would you rate their performance? (Scale from 1-5)

   A: ☒ **5** *Excellent* ☐ **4** *Good* ☐ **3** *Fair* ☐ **2** *Poor* ☐ **1** *Unacceptable*

7. **Q:** Is there anything else we should know, that we have not asked?
   A: We are very pleased with UnitedHealthcare's product and services

The undersigned does hereby certify that the foregoing and subsequent statements are true and correct and are made independently, free from vendor interference/collusion.

Name: Guy Hine Title Risk Manager

Signature: Guy Hine Date: February 13, 2015

City of Hollywood, Florida
Issue Date: January 30, 2015 Solicitation #RFP-4448-15-RD

REFERENCE QUESTIONNAIRE

It is the responsibility of the contractor/vendor to provide a minimum of three (3) similar type references using this form and to provide this information with your submission. Failure to do so may result in the rejection of your submission.

Giving reference for: UnitedHealthcare-Vision

Firm giving Reference: City of Hallandale Beach

Address: 400 S Federal Hwy, Hallandale Beach, FL 33009

Phone: 954-457-1347

Fax: 954-457-1494

Email: epantoja@hallandalebeachfl.gov

1. **Q:** What was the dollar value of the contract?
   A: $36,757.07
2. Have there been any change orders, and if so, how many?
   A: No
3. **Q:** Did they perform on a timely basis as required by the agreement?
   A: Yes
4. **Q:** Was the project manager easy to get in contact with?
   A: Yes
5. **Q:** Would you use them again?
   A: Yes
6. **Q:** Overall, what would you rate their performance? (Scale from 1-5)

   A: ☒ **5** *Excellent* ☐ **4** *Good* ☐ **3** *Fair* ☐ **2** *Poor* ☐ **1** *Unacceptable*
7. **Q:** Is there anything else we should know, that we have not asked?
   A: No

The undersigned does hereby certify that the foregoing and subsequent statements are true and correct and are made independently, free from vendor interference/collusion.

Name: Erika Pantoja Title Benefits Coordinator

Signature: see next page Date: 2/6/15

UHC Authorized Representative on behalf of the Group:

Angelo A. Golemi, Sales Executive - Key Accounts

Coyle, Jill

From: Pantoja, Erika <epantoja@hallandalebeachfl.gov>
Sent: Friday, February 06, 2015 4:45 PM
To: Marcalle, Arelis M
Subject: RE: Client Reference

Good afternoon Arelis,

Yes, you can list us as a reference and put myself as you contact. Good luck! ☺

Have a great weekend!

Erika Pantoja
Benefits Coordinator
City of Hallandale Beach
954-457-1347
954-457-1494 Fax

From: Marcalle, Arelis M [mailto:amarcalle@uhc.com]
Sent: Friday, February 06, 2015 12:14 PM
To: Pantoja, Erika
Subject: Client Reference

Erika,

UnitedHealthcare is currently bidding on the vision business for City of Hollywood. The bid is requesting references that closely match the demographics of this opportunity. Can you please let know if we can use City of Hallandale Beach as a client reference. If so, please let me know if you should be the contact.

I appreciate your cooperation.

Thanks!

Arelis Marcalle
Specialty Strategic Account Executive
Key Accounts
UnitedHealthcare
3100 SW 145th Avenue, Suite 200
Miramar, Florida 33027
Telephone: (954) 378-0470
E-Fax: (612) 367-0937
E-mail: amarcalle@uhc.com

***Our* United Culture. The way forward.**
■ Integrity ■ Compassion ■ Relationships ■ Innovation ■ Performance

"Highest in Customer Satisfaction with Vision and Dental Plans"
For J.D. Power award information, go to jdpower.com

Our Specialty Client Services team can assist employers and brokers with general administrative questions and a variety of benefit needs related to our products. Contact us at our toll free number, 1-888.866.3192, and press (1) for Life and Disability (2) for Vision or (3) for Dental. In addition, the Specialty Client Services team can also be reached at Specialty_Client_Services@uhc.com

This e-mail, including attachments, may include confidential and/or proprietary information, and may be used only by the person or entity to which it is addressed. If the reader of this e-mail is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this e-mail is prohibited. If you have received this e-mail in error, please notify the sender by replying to this message and delete this e-mail immediately.

The City of Hallandale Beach is a public entity subject to Chapter 119 of the Florida Statutes concerning public records. Email messages are covered under Chapter 119 and are thus subject to public records disclosure. All email messages sent and received are captured by our server and retained as public records. Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not send electronic mail to the City of Hallandale Beach. Instead contact us by phone or in writing (as noted above, any written communication received is subject to public records disclosure). Please refer to the Florida Statutes 119 for additional information.

UnitedHealthcare Vision

UnitedHealthcare Insurance Company

Certificate of Coverage

For

'07 Spectera Sample Customer
With 2011 Updates

(State = NA)

GROUP NUMBER: 123456001

EFFECTIVE DATE: January 1, 2011

SAMPLE

SAMPLE

UnitedHealthcare Insurance Company

Group Vision Care Certificate of Coverage

Issued To:	Sample Customer ("Enrolling Group")
Policy Number:	123456 001
Policy Effective Date:	January 1, 2011
Policy Anniversary Date:	January 1

This *Certificate of Coverage* ("*Certificate*") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR *CERTIFICATE* CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company (the "Company") agrees with the Enrolling Group to provide coverage for Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

Many words used in this *Certificate* and the attached *Table of Benefits* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions*. By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Table of Benefits*.

When we use the words "we", "us", "our", and "the Company" in this *Certificate*, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your", we are referring to the people who are Covered Persons as the term is defined in *Section 1: Definitions*.

The Policy is delivered in and governed by the laws of the State of Not Applicable.

SAMPLE

Group Vision Care Certificate of Coverage

Table of Contents

SAMPLE

Section 1: Definitions

Copayment - The charge, in addition to the Premium, that you are required to pay to a Network Provider for certain Services payable under the Policy. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider.

Covered Person - The Subscriber or an Enrolled Dependent but this term applies only while the person is enrolled under the Policy. Reference to "you" and "your" throughout this *Certificate* are references to Covered Persons.

Covered Contact Lens Selection - A selection of available contact lenses that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Dependent - A Covered Person who is:

1. The Subscriber's legal spouse. All references to the spouse of a Subscriber shall include Domestic Partner; or

2. A dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term "child" also includes a grandchild of either the Subscriber or the Subscriber's spouse. To be eligible for coverage under the Policy, a Dependent must principally reside within the United States. The definition of "Dependent" is subject to the following conditions and limitations:

    A. The term "Dependent" will not include any dependent child 26 years of age or older, except as stated in *Section 3: Termination Provisions* section titled "*Extended Coverage for Handicapped Dependent Children*".

The Subscriber agrees to reimburse the Company for any Services provided to the child at a time when the child did not satisfy these conditions.

The term "Dependent" also includes a child for whom coverage for Services is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a 'Qualified Medical Child Support Order'.

The term "Dependent" does not include anyone who is also enrolled as a Subscriber, nor can anyone be a "Dependent" of more than one Subscriber.

Domestic Partner - A person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.

Domestic Partnership - A relationship between the Subscriber and one other person of the opposite or same sex. The following requirements apply to both persons:

- They share the same permanent residence and the common necessities of life;
- They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- Each is at least 18 years of age;
- Each is mentally competent to consent to contract;
- Neither is currently married to another person under either a statutory or common law;
- They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:

SAMPLE

- Have a single dedicated relationship of at least 6 months duration.
- Joint ownership of residence.
- At least two of the following:
  - Joint ownership of an automobile.
  - Joint checking, bank or investment account.
  - Joint credit account.
  - Lease for a residence identifying both partners as tenants.
  - A will and/or life insurance policies which designates the other as primary beneficiary.

- The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.

Eligible Person - A person who meets all applicable eligibility requirements for vision care coverage.

Enrolled Dependent - A Dependent who is properly enrolled for coverage under the Policy.

Enrolling Group - The employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental, Investigational or Unproven Services - Medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - Services provided outside the U.S. and U.S. Territories.

Network Benefits - Coverage for Services provided by a Network Provider.

Non-Network Benefits - Coverage for Services provided by a provider other than a Network Provider.

Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services who has contracted, directly or indirectly, with us, to provide Services to Covered Persons participating in our vision plans.

Plan Year - A period of time beginning with the Policy Anniversary Date of any year and terminating exactly one year later. If the Policy Anniversary Date is February 29, such date will be considered to be February 28 in any year having no such date.

Policy - The Group Vision Care Insurance Policy issued to the Enrolling Group.

Premium - The periodic fee required to maintain coverage of Covered Persons in accordance with the terms of the Policy.

Service - Any covered benefit listed in *Section 4: Benefits* of this *Certificate*.

SAMPLE

Subscriber - An Eligible Person who is properly enrolled for coverage under the Policy and is the person on whose behalf the Policy is issued to the Enrolling Group.

SAMPLE

Section 2: Eligibility and Effective Dates

Effective Date of Coverage

In no event is there coverage for Services rendered or delivered before the effective date of coverage. Coverage will be effective subject to any applicable waiting period required by the Enrolling Group.

Enrollment

Eligible Persons may enroll themselves and their Dependents for coverage under the Policy during any enrollment period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date you first become eligible.

Coverage for a Newly Eligible Dependent

You may make coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In such cases you must submit the required contribution of coverage and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption. Otherwise, you will need to wait until the next enrollment period.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage shall take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.

SAMPLE

Section 3: Termination Provisions

Termination of Coverage

A Covered Person's coverage, including coverage for Services rendered after the date of termination for conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below:

1. The date the entire Policy is terminated for the reasons specified in the Policy. The Enrolling Group is responsible for notifying the Subscriber of the termination of the Policy.
2. The date the Covered Person ceases to be an Eligible Person.
3. The date requested in such notice when the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate coverage of the Subscriber or any Covered Person.
4. The date the Subscriber is retired or pensioned under the Enrolling Group's plan, unless a specific coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber:

5. The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information. Such information may include, but is not limited to, information relating to residence, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the Policy Effective Date.
6. The date specified by the Company that coverage will terminate due to material violation of the terms of the Policy.
7. The date specified by the Company that the Covered Person's coverage will terminate because the Covered Person has committed acts of physical or verbal abuse that pose a threat to the Company's staff, a provider, or other Covered Persons.
8. The date specified by the Company that all coverage will terminate because the Covered Person permitted the use of his or her ID card by any unauthorized person or used another person's card.
9. The date specified by the Company that your coverage will terminate because the Subscriber failed to pay a required Premium.

If covered Services are in progress on the date which coverage terminates, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Policy, failure to pay required Premiums, or acts of physical or verbal abuse.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by the Company when coverage was provided in error, except where that error was made by the Company.

Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age provided that:

A. The Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age;

SAMPLE

B. The Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance;

C. Proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and

D. Payment of any required contribution for the Enrolled Dependent is continued.

Coverage will continue so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Company will result in the termination of the Enrolled Dependent's coverage under the Policy.

SAMPLE

Section 4: Benefits

You will be provided with benefits for each of the listed Services as stated in the *Table of Benefits*. Your rights to benefits are subject to the terms, conditions, and exclusions of the Policy, including this *Certificate*, and any attached Amendments.

Obtaining Services

To find a Network Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Network Providers on the Internet at www.uhcspecialtybenefits.com.

You also may obtain Services from a non Network Provider. However, the amount of coverage may be reduced.

Foreign Services

Foreign Services will be treated as Non-Network benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. The Company makes no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published in the Wall Street Journal on the date the claim is processed.

SAMPLE

Section 5: Benefit Descriptions

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides, to include:

1. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
2. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
3. Cover test at 20 feet and 16 inches (checks eye alignment);
4. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;
5. Pupil responses (neurological integrity);
6. External exam;
7. Internal exam;
8. Retinoscopy (when applicable) - objective refraction to determine lens power of corrective Subjective refraction – to determine lens power of corrective lenses;
9. Phorometry/Binocular testing - far and near: how well eyes work as a team;
10. Tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.);
11. Tonometry, when indicated: test pressure in eye (glaucoma check);
12. Ophthalmoscopic examination of the internal eye;
13. Confrontation visual fields;
14. Biomicroscopy;
15. Color vision testing;
16. Diagnosis/prognosis; and
17. Specific recommendations.

Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

SAMPLE

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Necessary Contact Lenses

This benefit is available where a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by us.

Contact lenses are necessary if the Covered Person has:

1. Keratoconus or irregular astigmatism;
2. Anisometropia of 3.50 diopters or more;
3. Post-cataract surgery without intraocular lens; or
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

SAMPLE

Section 6: General Provisions

Legal Actions

No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed. No such action may be brought more than 3 years after the claim is required to be filed.

Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, will be used to void this Policy after it has been in force for a period of 2 years.

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Enrolling Group, are solely contractual relationships between independent contractors. Providers and the Enrolling Group are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Enrolling Group.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Enrolling Group is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage through the Company) and for the timely payment of the Policy Charge.

Assignment of Benefits

No assignment of the benefits or of payment for reimbursement is binding unless agreed to in writing. Such agreement is not valid until approved by us.

ERISA

When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., the Company is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of coverage under the Policy. A clerical error also does not create a right to benefits.

SAMPLE

Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Workers' Compensation Not Affected

The coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Table of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Table of Benefits*, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Table of Benefits*.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Table of Benefits* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Table of Benefits*.

Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Table of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Table of Benefits* to the greatest extent legally permissible.

SAMPLE

Section 7: Claims

Notice of Claim

Notice of claim as determined by us must be given to us within 365 days of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

When obtaining Services from a Network Provider, you will be required to pay a Copayment and any charges not covered by the Policy to your Provider. When obtaining Services from a Network Provider, you will not be required to submit a claim form.

When obtaining Services from a non-Network Provider, you will be required to pay all billed charges to your provider. You may then obtain reimbursement from us for the covered portion of Services.

Reimbursement

To file a claim for reimbursement for Services rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider), provide the following information on claim form acceptable to the Company:

1. Your itemized receipts;
2. Subscriber name;
3. Subscriber's identification number;
4. Patient name; and
5. Patient date of birth.

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Reimbursements are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss.

Examination of Covered Persons

In the event of a question or dispute concerning coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Network Provider acceptable to the Company.

SAMPLE

Section 8: Complaint Procedures

Complaint Resolution

If you have a concern or question regarding the provision of Services or benefits under the Policy, you should contact the Company's customer service department. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

The patient's name and identification number.

The date(s) of service(s).

The provider's name.

The reason you believe the claim should be paid.

Any new information to support your request for claim payment.

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or vision experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following the receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

SAMPLE

Section 9: Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to you from: (i) third parties, including any person alleged to have caused you to suffer injuries or damages; (ii) your employer; or (iii) any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). You agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company, plus reasonable costs of collection.

You will cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement, and acknowledge that the Company's rights will be considered as the first priority claim against Third Parties, to be paid before any other claims by you are paid. You will do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Policy. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name. For the reasonable value of services provided under the Policy, the Company may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether or not you have been fully compensated. You will hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions and the Company will be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you. You will not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. You agree to execute and deliver such documents (including a written confirmation of assignment, and consent to release vision records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.

SAMPLE

Section 10: Refund of Expenses

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

B. All or some of the payment made by the Company exceeded the benefits under the Policy; or

C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Refund of Benefits Paid by Third-Parties

If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

SAMPLE

Section 11: Exclusions

The following Services and materials are excluded from coverage under the Policy:

1. Non-prescription items (e.g. Plano lenses).
2. Services that the Covered Person, without cost, obtains from any governmental organization or program.
3. Services for which the Covered Person may be compensated under Worker's Compensation Law, or other similar employer liability law.
4. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Medical or surgical treatment for eye disease, which requires the services of a physician.
6. Replacement or repair of lenses and/or frames that have been lost or broken.
7. Optional Lens Extras not listed in the *Table of Benefits*.
8. Missed appointment charges.
9. Applicable sales tax charged on Services.
10. Services that are not specifically covered by the Policy.
11. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

SAMPLE

Group Vision Care Table of Benefits

Third Party Administrator: Spectera, Inc.

Claim Administrator: United HealthCare Insurance Company, 6220 Old Dobbin Lane, Columbia, MD 21045. Telephone No. 1-800-839-3242

The following Services will be covered in full, subject to a Copayment, when obtained from Network Providers.

When obtaining these Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Copayment at a Network Provider" in the chart below.

When obtaining these Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

SERVICE	FREQUENCY OF SERVICE	COPAYMENT AT A NETWORK PROVIDER	NON-NETWORK BENEFIT
Routine Vision Examination	Once every 12 months	$10.00	Up to $40.00
Eyeglass Frames	Once every 24 months[1]	$25.00[2] (100% of the billed charge to a maximum of $130.00)	Up to $45.00
Eyeglass Lenses	Once every 12 months[1]		
• Single Vision		$25.00[2]	Up to $40.00
• Bifocal		$25.00[2]	Up to $60.00
• Trifocal		$25.00[2]	Up to $80.00
• Lenticular		$25.00[2]	Up to $80.00
Contact Lenses	Once every 12 months[1]	$25.00 from the Covered Contact Lens Selection[3]	Up to $105.00
• Necessary		$25.00	Up to $210.00

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered in full:
  - Standard scratch-resistant coating

[1]You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

[2]If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

SAMPLE

[3]You may purchase from your Network Provider Contact Lenses that are outside of the Covered Contact Lens Selection. Non-selection Contact Lenses will receive an allowance of $105.00. No Copayment will apply to non-selection Contact Lenses.

SAMPLE

UNITEDHEALTHCARE VISION

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: April 14, 2003

SAMPLE

We* are required by law to protect the privacy of your health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that related to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our web site www.uhcspecialtybenefits.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; AmeriChoice of New Jersey, Inc; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, In.; Dental Benefit Providers of California, Inc.; Dental benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- ***For Payment*** of premiums due us and to process claims for health care services you receive.
- ***For Treatment***. We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- ***For Health Care Operations***. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- ***To Plan Sponsors***. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- ***For Appointment Reminders***. We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- ***To Persons Involved With Your Care***. We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- ***For Public Health Activities*** such as reporting disease outbreaks.
- ***For Reporting Victims of Abuse, Neglect or Domestic Violence*** to government authorities, including a social service or protective service agency.
- ***For Health Oversight Activities*** such as governmental audits and fraud and abuse investigations.
- ***For Judicial or Administrative Proceedings*** such as in response to a court order, search warrant or subpoena.
- ***For Law Enforcement Purposes*** such as providing limited information to locate a missing person.
- ***To Avoid a Serious Threat to Health or Safety*** by, for example, disclosing information to public health agencies.
- ***For Specialized Government Functions*** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- ***For Workers Compensation*** including disclosures required by state workers compensation laws of job-related injuries.

SAMPLE

- ***Provide Information Regarding Decedents***. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information**. If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, refer to "Exercising Your Rights" on page 4 of this notice.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information*.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

SAMPLE

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, **www.uhcspecialtybenefits.com**

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

United Healthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

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Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; United HealthCare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; United HealthCare Service LLC; United Medical Resources, Inc.*

SAMPLE

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

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HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

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Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy on the day before a qualifying event:

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.

B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.

B. Reduction in the subscriber's hours of employment.

C. Death of the subscriber.

D. Divorce or legal separation of the subscriber.

E. Loss of eligibility by an enrolled dependent who is a child.

F. Entitlement of the subscriber to Medicare benefits.

G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   - Notice of such disability must be provided within the latest of 60 days after:
   - the determination of the disability; or
   - the date of the qualifying event; or
   - the date the Qualified Beneficiary would lose coverage under the policy; and
   - in no event later than the end of the first eighteen months.
   - The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
   - If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

   Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).

C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:

   - Eighteen months from the date of the subscriber's Medicare entitlement; or
   - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

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- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
- The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
- If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the policy for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.

H. The date the entire policy ends.

I. The date coverage would otherwise terminate under the policy.

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Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information About Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

You are entitled to receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review this *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal

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fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *United States Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

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STATEMENT OF POLICY

UnitedHealth Group has a commitment to Equal Employment Opportunity (EEO) and to a work environment free of harassment. The policy of UnitedHealth Group is that people will be employed and promoted on the basis of their individual qualifications for the job and without regard to race, color, creed, public assistance, gender, religion, sexual orientation, national origin, marital status, age, disabilities, or status as a special disabled Veteran, Veteran of the Vietnam era, other eligible protected veteran, or any other characteristic protected under federal, state or local laws.

UnitedHealth Group will provide:

1. freedom from abusive, intimidating or offensive behavior on the part of supervisors or other employees. In this regard it should be understood that harassment of any sort will not be tolerated and that term includes derogatory ethnic, racial or sexist remarks;

2. freedom from sexual harassment. This refers to behavior which is not welcome, which is personally offensive and which interferes with the work effectiveness of its victims and their co-workers. A separate memorandum on this subject further amplifies the Policy and is distributed to all employees;

3. freedom from any form of discrimination or abusive intimidating or abusive behavior on the part of any supervisor or other employee as a result of a person's sexual orientation;

4. benefits and services as outlined in Company publications; and

5. UnitedHealth Group has written Affirmative Action Plans for 1) minorities and women and 2) individuals with disabilities, Veterans of the Vietnam era, and special disabled Veterans, and other eligible veterans.

Anyone with a question about UnitedHealth Group's Equal Employment Opportunity Policy should contact HRdirect at 1-800-561-0861. All concerns will be handled in confidence.

UnitedHealth Group has an approved Affirmative Action Program on file. Upon request, UnitedHealth Group will make available elements of this program in order to enable employees and applicants to know of and avail themselves of its benefits.

A person's race, religion, gender, sexual orientation, national origin, marital status, age, veteran status or disability must not affect our estimation of their character if we are to achieve the objectives of our business, our society, and our country. These moral and economic reasons for supporting the Company policy of nondiscrimination are to be of primary concern to all employees.

Standard Printing Cost Sheet	
Description	**Cost**
Printing Costs	
Black and white standard copy	$0.03 each
Color standard copy	$0.28 each
Black and white card stock copy	$0.07 each
Four-color card stock copy	$0.32 each
Black and white special copy (e.g., glossy, semi-gloss)	$0.09 each
Four-color special copy (e.g., glossy, semi-gloss)	$0.29 each
Price breaks – cost savings for printing in larger quantities	
Price break for 1,000 copies	1% discount
Price break for 5,000 copies	12% discount
Price break for 10,000 copies	37% discount
Price break for 20,000 copies	48% discount
Price break for 50,000 copies	58% discount
Price break for 100,000 copies	63% discount
Price break for 200,000 copies	66% discount
Design Costs	
Creation of new design for collateral or other materials	$70/hour if done by printing company $135/hour if done by agency
Edit existing design for collateral or other materials	$55/hour if done by printing company $105/hour if done by agency

Note: All setup fees and additional customization for newly designed and existing marketing pieces will be an added cost. Paper weight will also affect the cost per sheet. Pricing varies depending on print vendor used and creative agency involved. All translations are handled through a third-party company and added expense will be determined at time needed.

All prices are subject to change without prior notification.

How to Use Your Vision Care Benefits

Step 1. Review your Customized Benefits

Carefully review your customized benefits to determine your plan design and applicable copays. A copy of your benefits brochure may be obtained from your benefits representative, or you can access the **My Benefits** page of our Web site to see the specifics of your plan.

Step 2. Find a Conveniently Located Provider

You may easily locate providers by selecting the **provider locator** option from the left-hand menu on our Web site.

Step 3. Schedule Your Appointment

Once a provider is chosen, simply call the provider directly to schedule your appointment. Be prepared to identify yourself as a UnitedHealthcare Vision member and provide the member identification number listed on your ID card below, primary insured's last name, patient's name and date of birth. To help ensure the provider is able to process your insurance be sure to take this ID card to your appointment.

Step 4. Receive Your Eye Exam

The network provider, a state-licensed optometrist or ophthalmologist, will perform a complete eye exam, which includes a case history of the patient and an examination for eye disease and vision impairment. Should vision correction be required your provider will determine your specific prescription for glasses or contacts. Should a disease or eye disorder be found you may be referred to your health plan for medical eye coverage.

Step 5. Choose Your Eyewear

If prescription eyewear is necessary, your provider will assist you with your selection and order your prescription. Prescription eyewear includes eyeglasses and/or contacts depending on your plan coverage. Once your eyewear is complete your provider will schedule a time for pick up. Eyewear is dispensed at the provider's office to ensure optical accuracy and proper fit. If you have any questions or concerns about your glasses or contacts let your provider know; they are there to help you both during and after your appointment.

Out-of-Network Benefits*

While the greatest benefit is applied if you stay with a network provider, most plans cover a portion of your exam and eyewear should you choose to use an out-of-network provider. You will be required to pay for your purchases at the time of service and request reimbursement from UnitedHealthcare Vision. To confirm if you have out-of-network coverage please consult your benefit summary or the *out-of-network reimbursement link* located on the My Benefits page of the Web site. Please confirm that out-of-network benefits are available prior to scheduling your appointment. In order to receive reimbursement, simply submit the itemized paid receipt(s), along with the member identification number and patient's name and date of birth.

Questions?

Your satisfaction is very important to us — we encourage you to contact us with any questions you may have and to share your feedback by calling our toll-free number: 1.800.638.3120

UnitedHealthcare Vision℠

Member □□□ □:	John Doe
□ □□ □□□□□:	xxx-xx-1234
Member Web:	www.myuhcvision.com
Customer Service:	1.800.638.3120

Vision Identification Card

fold here

Vision Care Benefits

Exam Copay:	$10
Material Copay:	$25

Submit Out-of-Network Claims to:
UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Note to Providers:

OptumHealth Vision

For more information about this UnitedHealthcare Vision plan (formerly Spectera) or to receive authorization for service, please visit us online at www.optumhealthvision.com or call 1-800-638-3120.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06 and associated COC form number VCOC.INT.06.TX.

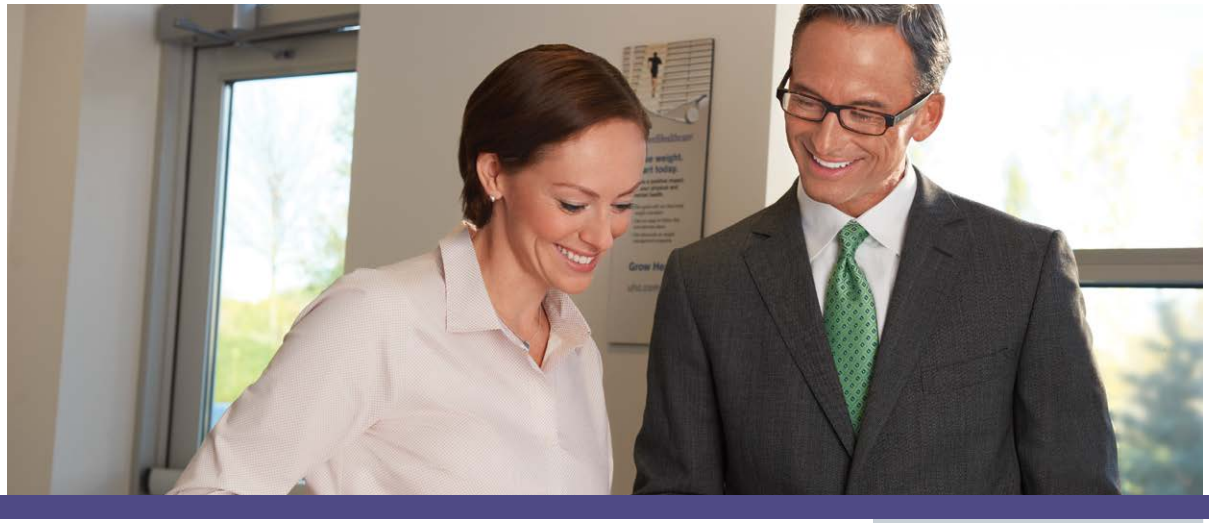
OnlineID-rev.3/2010

** Out-of-network benefits are not available on all plans. Please verify eligibility prior to going to an out-of-network provider.*

Vision

Vision insurance

Many vision plan benefits, many ways to see savings



A vision plan from UnitedHealthcare makes it easy to maintain good sight and healthy eyes, and save money while you're at it. As a member, you get a comprehensive eye exam. If you need glasses or contact lenses, you'll pay little or no out-of-pocket cost. You'll also get big discounts on popular lens options.

"Highest in Customer Satisfaction with Vision Plans, Two Years in a Row"

Our vision plan provides you with:

- Eye exams
- Complete set of eyeglasses or contacts (check your plan for details)
- A national eye care network including both retail and private practice locations

As a member you also have access to:

- Discounts on laser vision correction
- Discounts on extra pairs of eyewear
- 20% to 40% discount on popular lens options (like progressives and tints)
- Preferred pricing on premium hearing aids

Refer to your benefit summary for plan details

UnitedHealthcare®

Thousands of private practice locations plus **hundreds** of well-known retail chain locations including these brands.

America's Best Contacts & Eyeglasses · Costco Wholesale · Eyeglass World · For Eyes · Visionworks · Walmart

Finding the right eye care provider is easy.

Our large national network has ophthalmologists and optometrists in both private practice and retail settings. Choose the eyewear and eye doctor that meet your needs and schedule. If you need evening or weekend hours there is a network vision provider for you.

To find a provider near you, go to **myuhcvision.com** and use the provider locator tool for a complete listing, including door-to-door directions. Or call **1-800-638-3120** to speak with a customer care professional.

Contact lens benefit.

If you wear contact lenses instead of eyeglasses, UnitedHealthcare covers the fitting and evaluation fees, contact lenses (including disposables) and up to two follow-up visits with your eye doctor. Some of the most popular contact lenses are included in our covered-in-full section, but if the chosen contacts are not on the selection list, they are not covered in full. Instead, you get an allowance toward the purchase price and we waive the co-payment.

Access to Discounts on Contact Lenses.

And if you have a prescription for contact lenses from your eye doctor, you can use our online ordering program for 10% off contact lenses, after you have used your covered benefit. Just visit **myuhcvision.com** and click on the *"Order Contact Lenses"* button.

Frame benefit.*

When you visit a provider within the UnitedHealthcare vision network, you will get an allowance that can be applied to the cost of your frames. This allowance covers in full, after your materials co-pay, many of the most popular frames on the market today.

Lens upgrades.**

Get discounts of up to 40% on popular lens options like progressive lenses, tints, and anti-reflective coating, if not already covered by your plan. Standard scratch resistant coating is applied to all lenses at no charge.

Additional pairs of glasses.

You get a 20% discount on any additional pairs of eyeglasses. This includes prescription sunglasses at participating providers.

Access to discounted laser vision correction.

You get access to discounted laser vision correction procedures. You can choose a credentialed surgeon from Laser Vision Network of America's (LVNA) nationwide network of more than 550 laser vision correction surgeons.

Preferred Pricing on Hearing Aids.

You can buy high-quality, digital hearing aids at discounted prices, starting at $699 each through *hi HealthInnovations™*. These hearing aids use advanced technology to help you hear and understand speech better.

Print an ID card.

With our convenient paperless benefits and claims, you don't need a member ID card to use your benefits. However, if you'd like one, you can easily print one from **myuhcvision.com.** Your card will be personalized with your name, member ID, as well as your exam and materials co-pay amounts.

Login or register on **myuchvision.com**. Click on the *"Print ID Card"* button. This generates a document called How to Use Your Vision Care Benefits. Scroll to the bottom of this document. A toolbar will appear; click on the printer icon to print.

Online. All the time.

myuhcvision.com lets you easily verify your benefits and eligibility, find answers to frequently asked questions, locate a provider, access online offers and services, print a member ID card, and much more.

Did you know?

Healthy eyes start with an eye exam. Eye problems are the second most common health concern in the United States. Through a dilated eye exam, eye doctors are able to see inside your eye. This lets your eye doctor find the first signs of illnesses that can affect your entire body. This lets treatment start early, even before you knew there was a problem. Eye doctors can help you find a primary care doctor to care for illnesses found during your exam. They are also part of your team for ongoing care to watch for changes in your conditions.

The skilled eye doctors in our network can help you keep your eyes healthy. Visit **myuhcvision.com** for more details on your coverage and to find a provider.

Quick fact:

Research has shown that the eyes provide the only non-invasive view of our blood vessels. A comprehensive eye exam may be the first line of defense against diseases such as diabetes, hypertension and heart disease. Make your annual eye exam an important part of your preventive care.

Get great care and big savings.

Enroll today. We look forward to helping you see the benefits of your vision plan.

UnitedHealthcare®

*Frame discounts do not apply when prohibited by frame manufacturer.

**Not available in all states. Check with your provider.

UnitedHealthcare received the highest numerical score in the proprietary J.D. Power 2013-2014 Vision Plan Satisfaction Report℠. 2014 report measures opinions of consumers with vision plans, includes four plans, and is based on responses from 3,063 consumers. Proprietary study results are based on experiences and perceptions of consumers surveyed October – November 2014. Your experiences may vary. Visit www.jdpower.com

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

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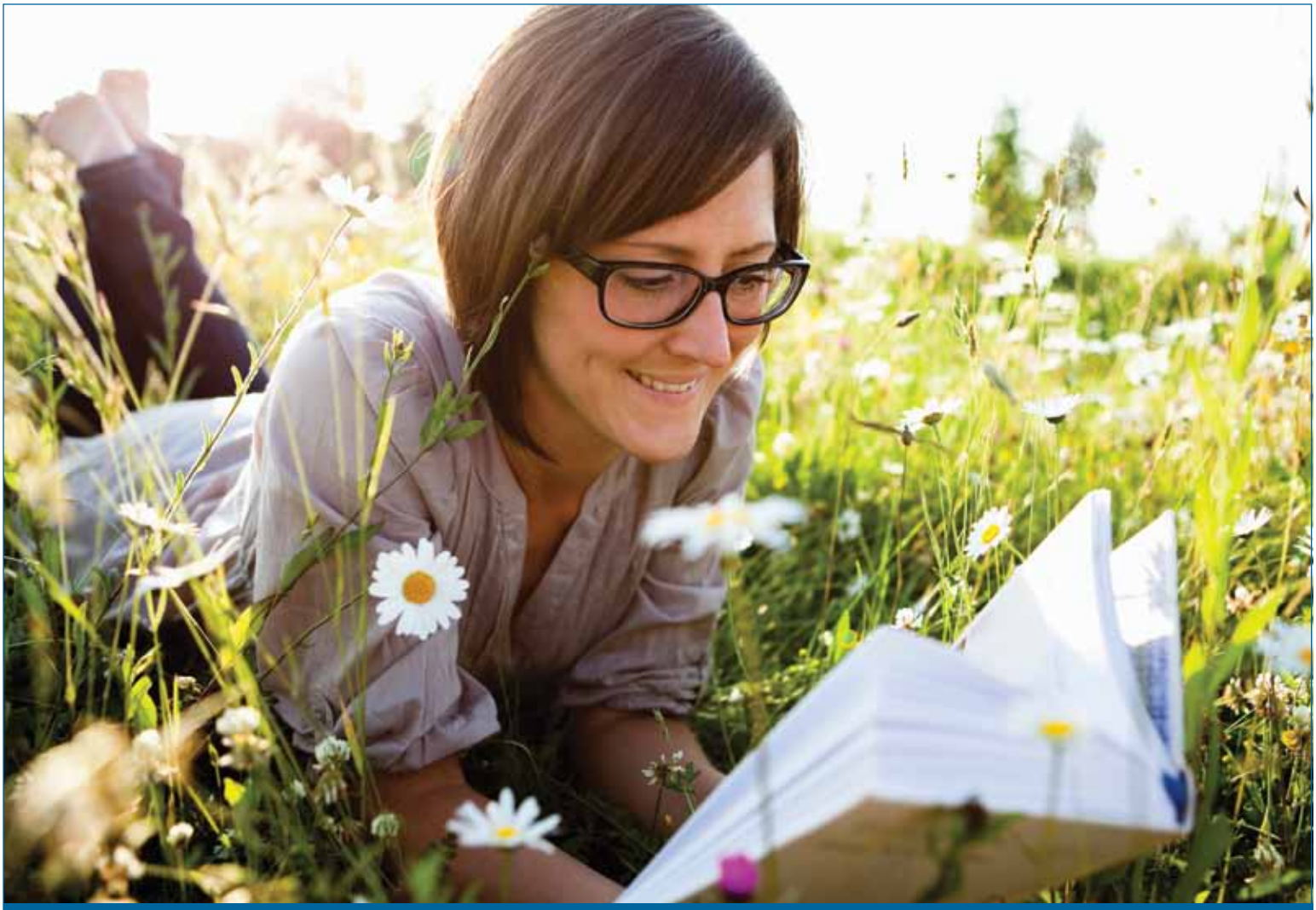

Your Vision Benefits Welcome Guide

UnitedHealthcare®

Let's get started.

Welcome. We are excited that you have chosen a vision plan from UnitedHealthcare. We'll do everything we can to meet your expectations with good care and service.

This guide will help you understand:

- How to use your vision plan
- What's covered
- How to get answers to your questions

Take a few minutes to review this information and remember that we're here to help if you have any questions. Visit **myuhcvision.com** or call **1-800-638-3120**.

Your ID card

You do not need a member ID card to use your benefits. However, if you'd like one, you can easily print one from **myuhcvision.com.** Once you've logged in, click on "Print ID Card" from the main dashboard page.

Five Things To Know:

1. You have access to a **national network of providers,** including optometrists and ophthalmologists as well as the choice of either a private practice or retail setting.
2. Your plan includes a fully covered **eye exam with eyeglasses or contacts,** after applicable copayment.
3. You are not limited to a small selection of **eyeglass frames.** Your plan includes an allowance that can be applied to any frame available at your participating provider's office.
4. Your **contact lens** benefit applies to the evaluation, fitting fees and purchase of contact lenses as well as two follow-up visits.
5. There's a website just for you: **myuhcvision.com.**

What's covered by my plan?

Exams Your eye doctor will give you a complete eye exam. This exam includes a case history and an exam for eye illness and vision impairment. If an illness or eye disorder is found you may be referred to your health plan for medical eye coverage.

Frame* Benefit When you visit a network provider, your plan gives you an amount of money you can apply toward the cost of your frames, or an allowance. This allowance (after your copay) is enough to cover many of the most popular frames on the market today.

Contact Lens Benefit If you wear contact lenses, our selection includes the most popular brands on the market today. Your vision benefit (after your copay) covers contact lenses, fitting, and up to two follow-up visits. The contact lens selection varies, depending on your plan and what your vision provider sells. You can also use your plan's allowance toward other brands of contact lenses (non-selection), the fitting and up to two follow up visits.

Access to Discounts on Contact Lenses And if you have a prescription for contact lenses from your eye doctor, you can use our online ordering program for 10% off contact lenses, after you have used your covered benefit. Just click on the "Discounts on Contact Lenses" button.

Lens Upgrades Popular lens options, like progressive lenses, tints, anti-reflective coating and more, if not covered by your plan, are available at discounts of up to 40%. Standard scratch-resistant coating is included **at no charge**.

Additional Pairs of Glasses You get a 20% discount on any additional pairs of eyeglasses. This includes prescription sunglasses.

Access to Discounted Laser Vision Correction You have access to discounted laser vision correction procedures through Laser Vision Network of America's (LVNA) nationwide network of more than 550 credentialed surgeons.

Preferred Pricing on Hearing Aids You can buy high-quality, digital hearing aids at an discounted prices, starting at $699 each through hi HealthInnovations™. These hearing aids use advanced technology to help you hear and understand speech better.

Example of possible savings with a vision plan

(Copays and discounts vary by plan.)

	With vision benefit	Without a vision benefit	You save
Routine exam[1]	$10 copayment*	Average cost $89	$79
Frames[2]	$130 allowance 30% discount on remaining amount (if any)[3]	Average cost $189	$148
Standard lenses Single-vision lenses Lined bifocal lenses Lined trifocal lenses	$25 copayment*[4]	 Average retail cost $59 Average retail cost $109 Average retail cost $149	 $34 $84 $124

This information is a generalized savings example and is not reflective of any specific plan or provider costs. The charges for services and materials without a plan may vary by provider. In the example above, charges for services without a vision plan were derived from internal data provided by our company-owned retail stores and contracted retail chains.

* Copayment and plan allowance(s) may vary based on your individual plan This example is based upon a typical copay. Please check your vision plan benefit information for details.

[1] Routine eye exam with refraction.
[2] Frame discounts do not apply when prohibited by frame manufacturer.
[3] Receive a $130 frame allowance applied toward the retail price of a frame at any network provider. If the frame costs more than the allowance, you are only responsible for the difference, plus any applicable copay. Discount may be applied at participating network locations.
[4] The materials copay is a single payment that applies to the entire purchase of eyeglasses or contacts in lieu of eyeglasses.

How do I make the most of my plan?

Your UnitedHealthcare vision plan makes it easy to maintain good eyesight and healthy eyes, and save money while you are at it. Your plan offers you the flexibility to use any provider you choose, but typically the best overall savings are available at network locations. Visiting a network location also gives you the opportunity to take advantage of eyewear discounts on options like lens upgrades. Your vision plan allows you to pick the provider that matches your lifestyle and eye care needs.

Finding a provider is easy.

Simply go to **myuhcvision.com** and use the provider locator tool for a complete list, including door-to-door directions. You may also find a network provider by accessing UnitedHealthcare's interactive voice response system. Follow the voice prompts – it's as simple as that!

1-800-839-3242.

Your Plan in Four Easy Steps

1 Find a provider.

Use the Provider Locator tool on **myuhcvision.com** or call **1-800-839-3242.**

2 Schedule an appointment.

Call the vision provider to schedule an appointment. Tell them you have UnitedHealthcare vision coverage. All you need to provide is your last name and date of birth.

3 Get your eye exam.

The network provider, a state-licensed ophthalmologist or optometrist, will perform a comprehensive eye exam.

4 Choose eyewear.

Prescription eyewear includes eyeglasses and/or contacts depending on your plan coverage. Once your eyewear order is complete, your provider will schedule a time for pickup.

myuhcvision.com

myuhcvision.com is a valuable tool that we provide for our members. This website allows you to locate providers, check claims, learn more about your coverage and access educational information about eye health and wellness.

Provider Locator:

This tool will help you locate a doctor who is part of our network, so you can begin saving today.

The easiest way to find a network provider is to log on to **myuhcvision.com**. You can search for the provider nearest your home or office, and find locations offering features such as wheelchair access, additional languages spoken, driving directions or weekend office hours.

If you don't see your provider, you can nominate them via the online form and UnitedHealthcare will make every attempt to contact them.

Learn More about Your Coverage:

Get the most from your benefits by viewing plan details. Check your current eligibility, copays, allowances, covered lens options and out-of-pocket costs. You can also find answers to frequently asked questions.

Scan the QR code to visit a special website with videos and other materials designed to help you understand your plan and improve your eye health, or visit **www.uhctogether.com/UHCVisionPlan.**

UnitedHealthcare®

*Frame discounts do not apply when prohibited by frame manufacturer.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-Q

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE QUARTERLY PERIOD ENDED SEPTEMBER 30, 2014

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE TRANSITION PERIOD FROM _____ TO _____

Commission file number: 1-10864

UNITEDHEALTH GROUP®

UnitedHealth Group Incorporated
(Exact name of registrant as specified in its charter)

Minnesota	**41-1321939**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota	
(Address of principal executive offices)	**55343 (Zip Code)**

(952) 936-1300
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of October 31, 2014, there were 959,791,117 shares of the registrant's Common Stock, $.01 par value per share, issued and outstanding.

UNITEDHEALTH GROUP

Table of Contents

PART I

ITEM 1. FINANCIAL STATEMENTS

UnitedHealth Group
Condensed Consolidated Balance Sheets
(Unaudited)

(in millions, except per share data)	September 30, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 7,233	$ 7,276
Short-term investments	1,979	1,937
Accounts receivable, net	3,826	3,052
Other current receivables, net	5,189	3,998
Assets under management	2,855	2,757
Deferred income taxes	520	430
Prepaid expenses and other current assets	1,361	930
Total current assets	22,963	20,380
Long-term investments	19,346	19,605
Property, equipment and capitalized software, net	4,309	4,010
Goodwill	32,357	31,604
Other intangible assets, net	3,579	3,844
Other assets	2,872	2,439
Total assets	$85,426	$81,882
Liabilities and shareholders' equity		
Current liabilities:		
Medical costs payable	$12,328	$11,575
Accounts payable and accrued liabilities	8,394	7,458
Other policy liabilities	5,792	5,279
Commercial paper and current maturities of long-term debt	2,925	1,969
Unearned revenues	1,691	1,600
Total current liabilities	31,130	27,881
Long-term debt, less current maturities	14,592	14,891
Future policy benefits	2,487	2,465
Deferred income taxes	1,901	1,796
Other liabilities	1,326	1,525
Total liabilities	51,436	48,558
Commitments and contingencies (Note 9)		
Redeemable noncontrolling interests	1,386	1,175
Shareholders' equity:		
Preferred stock, $0.001 par value — 10 shares authorized; no shares issued or outstanding	—	—
Common stock, $0.01 par value — 3,000 shares authorized; 962 and 988 issued and outstanding	10	10
Retained earnings	33,578	33,047
Accumulated other comprehensive loss	(984)	(908)
Total shareholders' equity	32,604	32,149
Total liabilities and shareholders' equity	$85,426	$81,882

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Operations
(Unaudited)

(in millions, except per share data)	Three Months Ended September 30, 2014	Three Months Ended September 30, 2013	Nine Months Ended September 30, 2014	Nine Months Ended September 30, 2013
Revenues:				
Premiums	$28,972	$27,356	$85,927	$81,850
Services	2,535	2,280	7,386	6,636
Products	1,080	825	3,115	2,325
Investment and other income	172	163	613	561
Total revenues	32,759	30,624	97,041	91,372
Operating costs:				
Medical costs	23,092	22,044	69,823	66,786
Operating costs	5,436	4,869	15,836	14,308
Cost of products sold	955	731	2,776	2,082
Depreciation and amortization	373	349	1,097	1,025
Total operating costs	29,856	27,993	89,532	84,201
Earnings from operations	2,903	2,631	7,509	7,171
Interest expense	(152)	(178)	(467)	(532)
Earnings before income taxes	2,751	2,453	7,042	6,639
Provision for income taxes	(1,149)	(883)	(2,933)	(2,393)
Net earnings	1,602	1,570	4,109	4,246
Earnings attributable to noncontrolling interests	—	—	—	(48)
Net earnings attributable to UnitedHealth Group common shareholders	$ 1,602	$ 1,570	$ 4,109	$ 4,198
Earnings per share attributable to UnitedHealth Group common shareholders:				
Basic	$ 1.65	$ 1.56	$ 4.21	$ 4.16
Diluted	$ 1.63	$ 1.53	$ 4.15	$ 4.09
Basic weighted-average number of common shares outstanding	969	1,004	977	1,009
Dilutive effect of common share equivalents	13	20	13	17
Diluted weighted-average number of common shares outstanding	982	1,024	990	1,026
Anti-dilutive shares excluded from the calculation of dilutive effect of common share equivalents	7	7	8	11
Cash dividends declared per common share	$0.3750	$0.2800	$1.0300	$0.7725

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Comprehensive Income
(Unaudited)

(in millions)	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Net earnings	$ 1,602	$ 1,570	$ 4,109	$ 4,246
Other comprehensive loss:				
Gross unrealized (losses) gains on investment securities during the period	(53)	26	427	(475)
Income tax effect	20	(9)	(155)	172
Total unrealized (losses) gains, net of tax	(33)	17	272	(303)
Gross reclassification adjustment for net realized gains included in net earnings	(30)	(31)	(183)	(137)
Income tax effect	11	11	67	50
Total reclassification adjustment, net of tax	(19)	(20)	(116)	(87)
Total foreign currency translation losses	(642)	(49)	(232)	(635)
Other comprehensive loss	(694)	(52)	(76)	(1,025)
Comprehensive income	908	1,518	4,033	3,221
Comprehensive income attributable to noncontrolling interests	—	—	—	(48)
Comprehensive income attributable to UnitedHealth Group common shareholders	$ 908	$ 1,518	$ 4,033	$ 3,173

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Changes in Shareholders' Equity
(Unaudited)

(in millions)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss): Net Unrealized Gains (Losses) on Investments	Accumulated Other Comprehensive Income (Loss): Foreign Currency Translation Losses	Total Shareholders' Equity
Balance at January 1, 2014	988	$ 10	$ —	$ 33,047	$ 54	$ (962)	$32,149
Net earnings attributable to UnitedHealth Group common shareholders				4,109			4,109
Other comprehensive income (loss)					156	(232)	(76)
Issuances of common shares, and related tax effects	12	—	130				130
Share-based compensation, and related tax benefits			320				320
Common share repurchases	(38)	—	(450)	(2,574)			(3,024)
Cash dividends paid on common shares				(1,004)			(1,004)
Balance at September 30, 2014	962	$ 10	$ —	$ 33,578	$ 210	$ (1,194)	$32,604
Balance at January 1, 2013	1,019	$ 10	$ 66	$ 30,664	$ 516	$ (78)	$31,178
Net earnings attributable to UnitedHealth Group common shareholders				4,198			4,198
Other comprehensive loss					(390)	(635)	(1,025)
Issuances of common shares, and related tax effects	16	—	397				397
Share-based compensation, and related tax benefits			312				312
Common share repurchases	(37)	—	(856)	(1,492)			(2,348)
Acquisition of noncontrolling interests and related tax effects			81				81
Cash dividends paid on common shares				(777)			(777)
Balance at September 30, 2013	998	$ 10	$ —	$ 32,593	$ 126	$ (713)	$32,016

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Condensed Consolidated Statements of Cash Flows
(Unaudited)

(in millions)	Nine Months Ended September 30, 2014	2013
Operating activities		
Net earnings	$ 4,109	$ 4,246
Noncash items:		
Depreciation and amortization	1,097	1,025
Deferred income taxes	(107)	93
Share-based compensation	269	255
Other, net	(253)	(118)
Net change in other operating items, net of effects from acquisitions and changes in AARP balances:		
Accounts receivable	(545)	(120)
Other assets	(819)	(590)
Medical costs payable	654	788
Accounts payable and other liabilities	1,126	392
Other policy liabilities	—	(68)
Unearned revenues	91	20
Cash flows from operating activities	5,622	5,923
Investing activities		
Purchases of investments	(7,823)	(8,798)
Sales of investments	5,810	3,779
Maturities of investments	2,266	3,871
Cash paid for acquisitions, net of cash assumed	(851)	(330)
Purchases of property, equipment and capitalized software	(1,121)	(986)
Proceeds from disposal of property, equipment and capitalized software	—	146
Other, net	(139)	45
Cash flows used for investing activities	(1,858)	(2,273)
Financing activities		
Acquisition of noncontrolling interest shares	—	(1,474)
Common stock repurchases	(3,024)	(2,348)
Cash dividends paid	(1,004)	(777)
Proceeds from common stock issuances	400	538
Repayments of long-term debt	(812)	(1,560)
Proceeds from (repayments of) commercial paper, net	1,355	(529)
Proceeds from issuance of long-term debt	—	2,235
Customer funds administered	(440)	308
Other, net	(285)	(76)
Cash flows used for financing activities	(3,810)	(3,683)
Effect of exchange rate changes on cash and cash equivalents	3	(87)
Decrease in cash and cash equivalents	(43)	(120)
Cash and cash equivalents, beginning of period	7,276	8,406
Cash and cash equivalents, end of period	$ 7,233	$ 8,286

See Notes to the Condensed Consolidated Financial Statements

UnitedHealth Group
Notes to the Condensed Consolidated Financial Statements
(Unaudited)

1. Basis of Presentation

Basis of Presentation

UnitedHealth Group Incorporated (individually and together with its subsidiaries, "UnitedHealth Group" and "the Company") is a diversified health and well-being company dedicated to helping people live healthier lives and making health care work better. The Company offers a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

The Company has prepared the Condensed Consolidated Financial Statements according to U.S. Generally Accepted Accounting Principles (GAAP) and has included the accounts of UnitedHealth Group and its subsidiaries. The year-end condensed consolidated balance sheet was derived from audited financial statements, but does not include all disclosures required by GAAP. In accordance with the rules and regulations of the U.S. Securities and Exchange Commission (SEC), the Company has omitted certain footnote disclosures that would substantially duplicate the disclosures contained in its annual audited Consolidated Financial Statements. Therefore, these Condensed Consolidated Financial Statements should be read together with the Consolidated Financial Statements and the Notes included in Part II, Item 8, "Financial Statements" of the Company's Annual Report on Form 10-K for the year ended December 31, 2013 as filed with the SEC (2013 10-K). The accompanying Condensed Consolidated Financial Statements include all normal recurring adjustments necessary to present the interim financial statements fairly.

On January 1, 2014, the Company realigned certain of its businesses to respond to changes in the markets it serves and the opportunities that are emerging as the health system evolves. The Company's Optum business platform took responsibility for certain technology operations and business processing activities with the intention of pursuing additional third-party commercial opportunities in addition to continuing to serve UnitedHealthcare. These activities, which were historically a corporate function, are now included in OptumInsight's results of operations. The Company's reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. See Note 10 for segment financial information.

Use of Estimates

These Condensed Consolidated Financial Statements include certain amounts based on the Company's best estimates and judgments. The Company's most significant estimates relate to estimates and judgments for medical costs payable and revenues, valuation and impairment analysis of goodwill and other intangible assets, estimates of other policy liabilities and other current receivables, valuations of certain investments, and estimates and judgments related to income taxes and contingent liabilities. Certain of these estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain and will likely change in subsequent periods. The impact of any change in estimates is included in earnings in the period in which the estimate is adjusted.

Accounting Policies

Industry Tax. The Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation or ACA) include an annual, nondeductible insurance industry tax (Industry Tax) to be levied proportionally across the insurance industry for risk-based health insurance products that began on January 1, 2014.

The Company estimates its liability for the Industry Tax based on a ratio of the Company's applicable net premiums written compared to the U.S. health insurance industry total applicable net premiums, both for the previous calendar year. The Company records in full the estimated liability for the Industry Tax at the beginning of the calendar year with a corresponding deferred cost that is amortized to operating costs on the Condensed Consolidated Statements of Operations using a straight-line method of allocation over the calendar year. The liability is recorded in accounts payable and accrued liabilities and the corresponding deferred cost is recorded in prepaid expenses and other current assets on the Condensed Consolidated Balance Sheets. In September 2014, the Company paid its 2014 Industry Tax liability of $1.3 billion. As of September 30, 2014 the unamortized asset related to the Industry Tax was $335 million. The Company has experienced a higher effective income tax rate in 2014 as compared to 2013 due to the nondeductible nature of the Industry Tax.

Premium Stabilization Programs. Since the beginning of 2014, Health Reform Legislation has included three programs designed to stabilize health insurance markets (Premium Stabilization Programs): a permanent risk adjustment program; a temporary risk corridors program; and a transitional reinsurance program (Reinsurance Program).

The risk-adjustment provisions of Health Reform Legislation are permanent regulations and apply to market reform compliant individual and small group plans in the commercial markets. Under the program, each covered member is assigned a risk score based upon demographic information and applicable diagnostic codes from the current year paid claims, in order to determine an average risk score for each plan in a particular state and market risk pool. Generally, a plan with an average risk score that is less than the state's average risk score will pay into a pool, while a plan with an average risk score that is greater than the state's average risk score will receive money from the pool.

The risk corridors provisions of Health Reform Legislation will be in place for three years and are intended to limit the gains and losses of individual and small group qualified health plans. Plans are required to calculate the U.S. Department of Health and Human Services (HHS) risk corridor ratio of allowable costs (defined as medical claims plus quality improvement costs adjusted for the impact of reinsurance recoveries and the risk adjustment program) to the defined target amount (defined as actual premiums less defined allowable administrative costs inclusive of taxes and profits). Qualified health plans with ratios below 97% are required to make payments to HHS, while plans with ratios greater than 103% will receive funds from HHS.

The Reinsurance Program is a temporary three year program that is funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements. Only issuers of market reform compliant individual plans are eligible for reinsurance recoveries from the risk pools.

None of the Premium Stabilization Programs have had a material impact on the Condensed Consolidated Financial Statements.

All other accounting policies disclosed in Note 2 of Notes to the Consolidated Financial Statements in Part II, Item 8, "Financial Statements" in the 2013 10-K remain unchanged.

Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board issued Accounting Standard Update (ASU) No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" (ASU 2014-09). ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect

upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

The Company has determined that there have been no other recently adopted or issued accounting standards that had, or will have, a material impact on its Condensed Consolidated Financial Statements.

2. Investments

A summary of short-term and long-term investments by major security type is as follows:

(in millions)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
September 30, 2014				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 1,839	$ 3	$ (3)	$ 1,839
State and municipal obligations	6,609	221	(4)	6,826
Corporate obligations	7,459	113	(22)	7,550
U.S. agency mortgage-backed securities	2,053	27	(13)	2,067
Non-U.S. agency mortgage-backed securities	884	10	(4)	890
Total debt securities — available-for-sale	18,844	374	(46)	19,172
Equity securities — available-for-sale	1,628	24	(16)	1,636
Debt securities — held-to-maturity:				
U.S. government and agency obligations	178	3	—	181
State and municipal obligations	28	—	—	28
Corporate obligations	311	—	—	311
Total debt securities — held-to-maturity	517	3	—	520
Total investments	$ 20,989	$ 401	$ (62)	$ 21,328
December 31, 2013				
Debt securities — available-for-sale:				
U.S. government and agency obligations	$ 2,211	$ 5	$ (21)	$ 2,195
State and municipal obligations	6,902	147	(72)	6,977
Corporate obligations	7,265	130	(60)	7,335
U.S. agency mortgage-backed securities	2,256	23	(61)	2,218
Non-U.S. agency mortgage-backed securities	697	12	(7)	702
Total debt securities — available-for-sale	19,331	317	(221)	19,427
Equity securities — available-for-sale	1,576	9	(13)	1,572
Debt securities — held-to-maturity:				
U.S. government and agency obligations	181	1	—	182
State and municipal obligations	28	—	—	28
Corporate obligations	334	—	—	334
Total debt securities — held-to-maturity	543	1	—	544
Total investments	$ 21,450	$ 327	$ (234)	$ 21,543

The fair values of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination date as of September 30, 2014 were as follows:

(in millions)	AAA	AA	Non-Investment Grade	Total Fair Value
2014	$ 212	$ —	$ —	$ 212
2013	164	—	—	164
2012	84	—	—	84
2011	17	—	—	17
2010	23	—	—	23
2009	6	—	—	6
Pre — 2009	370	2	12	384
U.S. agency mortgage-backed securities	2,065	2	—	2,067
Total	$ 2,941	$ 4	$ 12	$ 2,957

The Company includes any securities backed by Alt-A or subprime mortgages and any commercial mortgage loans in default in the non-investment grade column in the table above.

The amortized cost and fair value of available-for-sale debt securities as of September 30, 2014, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 2,068	$ 2,077
Due after one year through five years	7,055	7,152
Due after five years through ten years	4,955	5,068
Due after ten years	1,829	1,918
U.S. agency mortgage-backed securities	2,053	2,067
Non-U.S. agency mortgage-backed securities	884	890
Total debt securities — available-for-sale	$ 18,844	$ 19,172

The amortized cost and fair value of held-to-maturity debt securities as of September 30, 2014, by contractual maturity, were as follows:

(in millions)	Amortized Cost	Fair Value
Due in one year or less	$ 84	$ 85
Due after one year through five years	218	218
Due after five years through ten years	119	120
Due after ten years	96	97
Total debt securities — held-to-maturity	$ 517	$ 520

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

(in millions)	Less Than 12 Months		12 Months or Greater		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
September 30, 2014						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 747	$ (2)	$ 61	$ (1)	$ 808	$ (3)
State and municipal obligations	254	(2)	138	(2)	392	(4)
Corporate obligations	2,331	(12)	452	(10)	2,783	(22)
U.S. agency mortgage-backed securities	213	(1)	378	(12)	591	(13)
Non-U.S. agency mortgage-backed securities	279	(1)	120	(3)	399	(4)
Total debt securities — available-for-sale	$ 3,824	$ (18)	$ 1,149	$ (28)	$ 4,973	$ (46)
Equity securities — available-for-sale	$ 99	$ (4)	$ 95	$ (12)	$ 194	$ (16)
December 31, 2013						
Debt securities — available-for-sale:						
U.S. government and agency obligations	$ 1,055	$ (19)	$ 17	$ (2)	$ 1,072	$ (21)
State and municipal obligations	2,491	(62)	128	(10)	2,619	(72)
Corporate obligations	2,573	(51)	103	(9)	2,676	(60)
U.S. agency mortgage-backed securities	1,393	(51)	105	(10)	1,498	(61)
Non-U.S. agency mortgage-backed securities	289	(6)	26	(1)	315	(7)
Total debt securities — available-for-sale	$ 7,801	$ (189)	$ 379	$ (32)	$ 8,180	$ (221)
Equity securities — available-for-sale	$ 180	$ (13)	$ —	$ —	$ 180	$ (13)

The Company's unrealized losses from all securities as of September 30, 2014 were generated from approximately 5,100 positions out of a total of 22,000 positions. The Company believes that it will collect the principal and interest due on its debt securities that have an amortized cost in excess of fair value. The unrealized losses were primarily caused by interest rate increases and not by unfavorable changes in the credit quality associated with these securities. At each reporting period, the Company evaluates securities for impairment when the fair value of the investment is less than its amortized cost. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting neither a significant deterioration since purchase nor other factors leading to an other-than-temporary impairment (OTTI). As of September 30, 2014, the Company did not have the intent to sell any of the securities in an unrealized loss position. Therefore, the Company believes these losses to be temporary.

The Company's investments in equity securities consist of investments in Brazilian real denominated fixed-income funds, employee savings plan related investments, venture capital funds, and dividend paying stocks. The Company evaluated its investments in equity securities for severity and duration of unrealized loss, overall market volatility and other market factors.

Net realized gains reclassified out of accumulated other comprehensive income were from the following sources:

(in millions)	Three Months Ended September 30, 2014	Three Months Ended September 30, 2013	Nine Months Ended September 30, 2014	Nine Months Ended September 30, 2013
Total OTTI	$ (18)	$ (3)	$ (25)	$ (7)
Portion of loss recognized in other comprehensive income	—	—	—	—
Net OTTI recognized in earnings	(18)	(3)	(25)	(7)
Gross realized losses from sales	(3)	—	(42)	(3)
Gross realized gains from sales	51	34	250	147
Net realized gains (included in investment and other income on the Condensed Consolidated Statements of Operations)	30	31	183	137
Income tax effect (included in provision for income taxes on the Condensed Consolidated Statements of Operations)	(11)	(11)	(67)	(50)
Realized gains, net of taxes	$ 19	$ 20	$ 116	$ 87

3. Fair Value

Certain assets and liabilities are measured at fair value in the Condensed Consolidated Financial Statements or have fair values disclosed in the Notes to the Condensed Consolidated Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

Level 1 — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

Level 2 — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in nonactive markets (e.g., few transactions, limited information, noncurrent prices, high variability over time);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and
- Inputs that are corroborated by other observable market data.

Level 3 — Unobservable inputs that cannot be corroborated by observable market data.

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs; there were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during 2014 or 2013.

Nonfinancial assets and liabilities or financial assets and liabilities that are measured at fair value on a nonrecurring basis are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the nine months ended September 30, 2014 or 2013.

The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument included in the tables below:

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

Debt and Equity Securities. Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities, and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and nonbinding broker quotes. As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source, such as its custodian, its investment consultant and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures and reviews of fair value methodology documentation provided by independent pricing services have not historically resulted in adjustment in the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets but are priced using other observable inputs are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity securities and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The fair values of Level 3 investments in venture capital portfolios are estimated using a market valuation technique that relies heavily on management assumptions and qualitative observations. Under the market approach, the fair values of the Company's various venture capital investments are computed using limited quantitative and qualitative observations of activity for similar companies in the current market. The Company's market modeling utilizes, as applicable, transactions for comparable companies in similar industries that also have similar revenue and growth characteristics and preferences in their capital structure. Key significant unobservable inputs in the market technique include implied earnings before interest, taxes, depreciation and amortization (EBITDA) multiples and revenue multiples. Additionally, the fair values of certain of the Company's venture capital securities are based off of recent transactions in inactive markets for identical or similar securities. Significant changes in any of these inputs could result in significantly lower or higher fair value measurements.

Throughout the procedures discussed above in relation to the Company's processes for validating third-party pricing information, the Company validates the understanding of assumptions and inputs used in security pricing and determines the proper classification in the hierarchy based on that understanding.

AARP Program-related Investments. The Company provides health insurance products and services to members of AARP under a Supplemental Health Insurance Program (AARP Program). AARP Program-related investments consist of debt securities and other investments held to fund costs associated with the AARP Program and are priced and classified using the same methodologies as the Company's investments in debt and equity securities.

Interest Rate Swaps. Fair values of the Company's swaps are estimated using the terms of the swaps and publicly available information including market yield curves. Because the swaps are unique and not actively traded but are valued using other observable inputs, the fair values are classified as Level 2.

Long-term Debt. The fair values of the Company's long-term debt are estimated and classified using the same methodologies as the Company's investments in debt securities.

AARP Program-related Other Liabilities. AARP Program-related other liabilities consist of liabilities that represent the amount of net investment gains and losses related to AARP Program-related investments that accrue to the benefit of the AARP policyholders.

The following table presents a summary of fair value measurements by level and carrying values for items measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets excluding AARP Program-related assets and liabilities, which are presented in a separate table below:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
September 30, 2014				
Cash and cash equivalents	$ 7,221	$ 12	$ —	$ 7,233
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,612	227	—	1,839
State and municipal obligations	—	6,826	—	6,826
Corporate obligations	—	7,490	60	7,550
U.S. agency mortgage-backed securities	—	2,067	—	2,067
Non-U.S. agency mortgage-backed securities	—	884	6	890
Total debt securities — available-for-sale	1,612	17,494	66	19,172
Equity securities — available-for-sale	1,323	12	301	1,636
Interest rate swap assets	—	21	—	21
Total assets at fair value	$ 10,156	$ 17,539	$ 367	$ 28,062
Percentage of total assets at fair value	36%	63%	1%	100%
Interest rate swap liabilities	$ —	$ 62	$ —	$ 62
December 31, 2013				
Cash and cash equivalents	$ 7,005	$ 271	$ —	$ 7,276
Debt securities — available-for-sale:				
U.S. government and agency obligations	1,750	445	—	2,195
State and municipal obligations	—	6,977	—	6,977
Corporate obligations	25	7,274	36	7,335
U.S. agency mortgage-backed securities	—	2,218	—	2,218
Non-U.S. agency mortgage-backed securities	—	696	6	702
Total debt securities — available-for-sale	1,775	17,610	42	19,427
Equity securities — available-for-sale	1,291	12	269	1,572
Total assets at fair value	$ 10,071	$ 17,893	$ 311	$ 28,275
Percentage of total assets at fair value	36%	63%	1%	100%
Interest rate swap liabilities	$ —	$ 163	$ —	$ 163

The following table presents a summary of fair value measurements by level and carrying values for certain financial instruments not measured at fair value on a recurring basis in the Condensed Consolidated Balance Sheets:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair Value	Total Carrying Value
September 30, 2014					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 181	$ —	$ —	$ 181	$ 178
State and municipal obligations	—	—	28	28	28
Corporate obligations	48	9	254	311	311
Total debt securities — held-to-maturity	$ 229	$ 9	$ 282	$ 520	$ 517
Long-term debt and other financing obligations	$ —	$ 16,557	$ —	$ 16,557	$ 15,047
December 31, 2013					
Debt securities — held-to-maturity:					
U.S. government and agency obligations	$ 182	$ —	$ —	$ 182	$ 181
State and municipal obligations	—	—	28	28	28
Corporate obligations	47	9	278	334	334
Total debt securities — held-to-maturity	$ 229	$ 9	$ 306	$ 544	$ 543
Long-term debt and other financing obligations	$ —	$ 16,602	$ —	$ 16,602	$ 15,745

The carrying amounts reported on the Condensed Consolidated Balance Sheets for other financial assets and liabilities approximate fair value because of their short-term nature. These assets and liabilities are not listed in the table above.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level 3 inputs is as follows:

	Three Months Ended			Nine Months Ended		
(in millions)	Debt Securities	Equity Securities	Total	Debt Securities	Equity Securities	Total
September 30, 2014						
Balance at beginning of period	$ 57	$ 302	$ 359	$ 42	$ 269	$ 311
Purchases	11	36	47	24	86	110
Sales	—	(18)	(18)	—	(169)	(169)
Net unrealized (losses) gains in other comprehensive income	(2)	(4)	(6)	—	6	6
Net realized (losses) gains in investment and other income	—	(15)	(15)	—	109	109
Balance at end of period	$ 66	$ 301	$ 367	$ 66	$ 301	$ 367
September 30, 2013						
Balance at beginning of period	$ 38	$ 245	$ 283	$ 17	$ 224	$ 241
Purchases	3	9	12	25	51	76
Sales	(7)	—	(7)	(7)	(21)	(28)
Net unrealized losses in other comprehensive income	—	(7)	(7)	(1)	(13)	(14)
Net realized (losses) gains in investment and other income	(1)	(1)	(2)	(1)	5	4
Balance at end of period	$ 33	$ 246	$ 279	$ 33	$ 246	$ 279

The following table presents quantitative information regarding unobservable inputs that were significant to the valuation of assets measured at fair value on a recurring basis using Level 3 inputs:

(in millions)	Fair Value	Valuation Technique	Unobservable Input	Range Low	Range High
September 30, 2014					
Equity securities — available-for-sale					
Venture capital portfolios	$ 245	Market approach — comparable companies	Revenue multiple	1.0	5.0
			EBITDA multiple	8.0	10.0
	56	Market approach — recent transactions	Inactive market transactions	N/A	N/A
Total equity securities available-for-sale	$ 301				

Also included in the Company's assets measured at fair value on a recurring basis using Level 3 inputs were $66 million of available-for-sale debt securities as of September 30, 2014, which were not significant.

The Company elected to measure the entirety of the AARP Program assets under management at fair value pursuant to the fair value option. See Note 2 of Notes to the Consolidated Financial Statements in Item II, Part 8, "Financial Statements" in the Company's 2013 10-K for further detail on the AARP Program. The following table presents fair value information about the AARP Program-related financial assets and liabilities:

(in millions)	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Total Fair and Carrying Value
September 30, 2014			
Cash and cash equivalents	$ 330	$ —	$ 330
Debt securities:			
U.S. government and agency obligations	409	245	654
State and municipal obligations	—	81	81
Corporate obligations	—	1,180	1,180
U.S. agency mortgage-backed securities	—	365	365
Non-U.S. agency mortgage-backed securities	—	166	166
Total debt securities	409	2,037	2,446
Other investments	—	79	79
Total assets at fair value	$ 739	$ 2,116	$ 2,855
Other liabilities	$ 4	$ 12	$ 16
December 31, 2013			
Cash and cash equivalents	$ 265	$ —	$ 265
Debt securities:			
U.S. government and agency obligations	426	301	727
State and municipal obligations	—	63	63
Corporate obligations	—	1,145	1,145
U.S. agency mortgage-backed securities	—	414	414
Non-U.S. agency mortgage-backed securities	—	139	139
Total debt securities	426	2,062	2,488
Equity securities—available-for-sale	—	4	4
Total assets at fair value	$ 691	$ 2,066	$ 2,757
Other liabilities	$ 3	$ 11	$ 14

4. Medicare Part D Pharmacy Benefits

The Condensed Consolidated Balance Sheets include the following amounts associated with the Medicare Part D program:

	September 30, 2014			December 31, 2013		
(in millions)	Subsidies	Drug Discount	Risk-Share	Subsidies	Drug Discount	Risk-Share
Other current receivables	$ 1,626	$ 592	$ —	$ 881	$ 425	$ —
Other policy liabilities	—	313	165	—	152	214

The Catastrophic Reinsurance and Low-Income Member Cost Sharing Subsidies (Subsidies) and drug discounts represent cost reimbursements under the Medicare Part D program. The Company is fully reimbursed by the Centers for Medicare & Medicaid Services (CMS) for costs incurred for these contract elements and, accordingly, there is no insurance risk to the Company. Amounts received for these contract elements are not reflected as premium revenues, but rather are accounted for as a reduction of receivables and/or increase in deposit liabilities. CMS provides prospective payments for the drug discounts, which the Company records as liabilities when received. The drug discounts are ultimately funded by the pharmaceutical manufacturers. The Company bills manufacturers for claims under the program and records those bills as receivables. Related cash flows for all of these cost reimbursements are presented as customer funds administered within financing activities on the Condensed Consolidated Statements of Cash Flows.

Premiums from CMS are subject to risk-sharing provisions based on a comparison of the Company's annual bid estimates of prescription drug costs and the actual costs incurred. Variances may result in CMS making additional payments to the Company or require the Company to remit funds to CMS subsequent to the end of the year. The Company records risk-share adjustments to premium revenue and to other current receivables or other policy liabilities on the Condensed Consolidated Balance Sheets. See Note 2 of Notes to the Consolidated Financial Statements in Item II, Part 8, "Financial Statements" in the Company's 2013 10-K for further detail on Medicare Part D.

5. Medical Cost Reserve Development

The following table provides details of the Company's favorable medical cost reserve development:

	Three Months Ended September 30,		Nine Months Ended September 30,	
(in millions)	2014	2013	2014	2013
Related to prior years	$ 120	$ 180	$ 380	$ 580
Related to current year	150	110	N/A	N/A

In both the three and nine months ended September 30, 2014, the favorable medical cost reserve development was driven by a number of individual factors that were not material. Lower than expected health system utilization levels were a significant driver in both the three and nine months ended September 30, 2013.

6. Commercial Paper and Long-Term Debt

Commercial paper and senior unsecured long-term debt consisted of the following:

(in millions, except percentages)	September 30, 2014			December 31, 2013		
	Par Value	Carrying Value	Fair Value	Par Value	Carrying Value	Fair Value
Commercial paper	$ 2,470	$ 2,470	$ 2,470	$ 1,115	$ 1,115	$ 1,115
4.750% notes due February 2014	—	—	—	172	173	173
5.000% notes due August 2014	—	—	—	389	397	400
Floating-rate notes due August 2014	—	—	—	250	250	250
4.875% notes due March 2015 (a)	416	422	424	416	431	436
0.850% notes due October 2015 (a)	625	625	627	625	624	628
5.375% notes due March 2016 (a)	601	627	641	601	641	657
1.875% notes due November 2016	400	398	407	400	398	408
5.360% notes due November 2016	95	95	104	95	95	107
6.000% notes due June 2017	441	471	494	441	479	506
1.400% notes due October 2017 (a)	625	614	624	625	613	617
6.000% notes due November 2017	156	166	176	156	168	178
6.000% notes due February 2018	1,100	1,114	1,250	1,100	1,116	1,271
1.625% notes due March 2019 (a)	500	493	489	500	489	481
3.875% notes due October 2020 (a)	450	445	482	450	435	474
4.700% notes due February 2021	400	414	446	400	416	436
3.375% notes due November 2021 (a)	500	487	516	500	472	494
2.875% notes due March 2022 (a)	1,100	1,020	1,094	1,100	981	1,046
0.000% notes due November 2022	15	10	11	15	9	10
2.750% notes due February 2023 (a)	625	590	604	625	563	572
2.875% notes due March 2023 (a)	750	760	732	750	729	698
5.800% notes due March 2036	850	845	1,040	850	845	935
6.500% notes due June 2037	500	495	656	500	495	593
6.625% notes due November 2037	650	646	852	650	645	786
6.875% notes due February 2038	1,100	1,085	1,506	1,100	1,084	1,370
5.700% notes due October 2040	300	298	362	300	298	329
5.950% notes due February 2041	350	348	440	350	348	397
4.625% notes due November 2041	600	593	620	600	593	567
4.375% notes due March 2042	502	486	497	502	486	459
3.950% notes due October 2042	625	611	581	625	611	530
4.250% notes due March 2043	750	740	733	750	740	673
Total commercial paper and long-term debt	$ 17,496	$ 17,368	$ 18,878	$ 16,952	$ 16,739	$ 17,596

(a) Fixed-rate debt instruments hedged with interest rate swap contracts. See below for more information on the Company's interest rate swaps.

The Company's long-term debt obligations also included $149 million and $121 million of other financing obligations, of which $33 million and $34 million were current as of September 30, 2014 and December 31, 2013, respectively.

Commercial Paper and Bank Credit Facilities

Commercial paper consists of short-duration, senior unsecured debt privately placed on a discount basis through broker-dealers. As of September 30, 2014, the Company's outstanding commercial paper had a weighted-average annual interest rate of 0.2%.

The Company has $3.0 billion five-year and $1.0 billion 364-day revolving bank credit facilities with 23 banks, which mature in November 2018 and November 2014, respectively. These facilities provide liquidity support for the Company's $4.0 billion commercial paper program and are available for general corporate purposes. There

were no amounts outstanding under these facilities as of September 30, 2014. The interest rates on borrowings are variable based on term and are calculated based on the London Interbank Offered Rate (LIBOR) plus a credit spread based on the Company's senior unsecured credit ratings. As of September 30, 2014, the annual interest rates on the bank credit facilities, had they been drawn, would have ranged from 1.0% to 1.2%.

Debt Covenants

The Company's bank credit facilities contain various covenants including requiring the Company to maintain a debt to debt-plus-equity ratio of not more than 50%. The Company was in compliance with its debt covenants as of September 30, 2014.

Interest Rate Swap Contracts

The Company uses interest rate swap contracts to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The floating rates are benchmarked to LIBOR. The swaps are designated as fair value hedges on the Company's fixed-rate debt. Since the critical terms of the swaps match those of the debt being hedged, they are considered to be highly effective hedges and all changes in the fair values of the swaps are recorded as adjustments to the carrying value of the related debt with no net impact recorded on the Condensed Consolidated Statements of Operations. Both the hedge fair value changes and the offsetting debt adjustments are recorded in interest expense on the Condensed Consolidated Statements of Operations. As of September 30, 2014 and December 31, 2013, the Company had interest rate swap contracts with notional amounts of $6.2 billion. As of September 30, 2014, the fair value of these swap assets totaling $21 million was recorded in other assets on the Condensed Consolidated Balance Sheets. The fair values of these swap liabilities were $62 million and $163 million, as of September 30, 2014 and December 31, 2013, respectively, which were recorded in other liabilities on the Condensed Consolidated Balance Sheets.

7. Shareholders' Equity

Share Repurchase Program

Under its Board of Directors' authorization, the Company maintains a share repurchase program. The objectives of the share repurchase program are to optimize the Company's capital structure and cost of capital, thereby improving returns to shareholders, as well as to offset the dilutive impact of share-based awards. Repurchases may be made from time to time in open market purchases or other types of transactions (including prepaid or structured share repurchase programs), subject to certain Board restrictions. In June 2014, the Board renewed the Company's share repurchase program with an authorization to repurchase up to 100 million shares of its common stock. During the nine months ended September 30, 2014, the Company repurchased 38 million shares at an average price of $79.35 per share and an aggregate cost of $3.0 billion.

Dividends

In June 2014, the Company's Board of Directors increased the Company's quarterly cash dividend to shareholders to equal an annual dividend rate of $1.50 per share compared to the annual dividend rate of $1.12 per share, which the Company had paid since June 2013. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

The following table provides details of the Company's 2014 dividend payments:

Payment Date	Amount per Share	Total Amount Paid
		(in millions)
March 25, 2014	$ 0.2800	$ 276
June 25, 2014	0.3750	366
September 23, 2014	0.3750	362

8. Share-Based Compensation

The Company's outstanding share-based awards consist mainly of nonqualified stock options, stock-settled stock appreciation rights (SARs) and restricted stock and restricted stock units (collectively, restricted shares).

Stock Options and SARs

Stock option and SAR activity for the nine months ended September 30, 2014 is summarized in the table below:

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life	Aggregate Intrinsic Value
	(in millions)		(in years)	(in millions)
Outstanding at beginning of period	41	$ 48		
Granted	8	71		
Exercised	(12)	46		
Forfeited	(1)	61		
Outstanding at end of period	36	53	5.3	$ 1,207
Exercisable at end of period	22	46	3.1	904
Vested and expected to vest, end of period	35	53	5.2	1,189

Restricted Shares

Restricted share activity for the nine months ended September 30, 2014 is summarized in the table below:

(shares in millions)	Shares	Weighted-Average Grant Date Fair Value per Share
Nonvested at beginning of period	11	$ 50
Granted	4	71
Vested	(6)	46
Nonvested at end of period	9	61

Other Share-Based Compensation Data

	Three Months Ended September 30,		Nine Months Ended September 30,	
(in millions, except per share amounts)	2014	2013	2014	2013
Stock Options and SARs				
Weighted-average grant date fair value of shares granted, per share	$ 17	$ 23	$ 22	$ 19
Total intrinsic value of stock options and SARs exercised	89	182	375	507
Restricted Shares				
Weighted-average grant date fair value of shares granted, per share	80	72	71	58
Total fair value of restricted shares vested	5	—	428	—
Share-Based Compensation Items				
Share-based compensation expense, before tax	81	79	269	255
Share-based compensation expense, net of tax effects	73	67	230	174
Income tax benefit realized from share-based award exercises	39	62	182	178

(in millions, except years)	September 30, 2014
Unrecognized compensation expense related to share awards	$ 438
Weighted-average years to recognize compensation expense	1.3

Share-Based Compensation Recognition and Estimates

The principal assumptions the Company used in calculating grant-date fair value for stock options and SARs were as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Risk-free interest rate	1.7%	1.6%	1.7% - 1.8%	1.0% - 1.6%
Expected volatility	27.2%	41.8%	27.2% - 39.6%	41.8% - 43.0%
Expected dividend yield	1.9%	1.5%	1.6% - 1.9%	1.4% - 1.5%
Forfeiture rate	5.0%	5.0%	5.0%	5.0%
Expected life in years	5.4	5.3	5.4	5.3

9. Commitments and Contingencies

Legal Matters

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services. These matters include medical malpractice, employment, intellectual property, antitrust, privacy and contract claims, and claims related to health care benefits coverage and other business practices.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred.

Litigation Matters

California Claims Processing Matter. On January 25, 2008, the California Department of Insurance (CDI) issued an Order to Show Cause to PacifiCare Life and Health Insurance Company, a subsidiary of the Company, alleging violations of certain insurance statutes and regulations related to an alleged failure to include certain language in standard claims correspondence, timeliness and accuracy of claims processing, interest payments, care provider contract implementation, care provider dispute resolution and other related matters. Although the Company believes that CDI had never before issued a fine in excess of $8 million, CDI advocated a fine of approximately $325 million in this matter. The matter was the subject of an administrative hearing before a California administrative law judge beginning in December 2009, and in August 2013, the administrative law judge issued a nonbinding proposed decision recommending a fine of $11.5 million. The California Insurance Commissioner rejected the administrative law judge's recommendation and on June 9, 2014, issued his own decision imposing a fine of approximately $174 million. On July 10, 2014, the Company filed a lawsuit in California state court challenging the Commissioner's decision. The Company cannot reasonably estimate the range of loss, if any, that may result from this matter given the procedural status of the dispute, the wide range of possible outcomes, the legal issues presented (including the legal basis for the majority of the alleged violations), the inherent difficulty in predicting a regulatory fine in the event of a remand, and the various remedies and levels of judicial review that remain available to the Company.

Endoscopy Center of Southern Nevada Litigation. In April 2013, a Las Vegas jury awarded $24 million in compensatory damages and $500 million in punitive damages against a Company health plan and its parent corporation on the theory that they were negligent in their credentialing and monitoring of an in-network

endoscopy center owned and operated by independent physicians who were subsequently linked by regulators to an outbreak of hepatitis C. The trial court reduced the overall award to $366 million. The Company is appealing the case. Company plans are party to 18 additional individual lawsuits and two class actions, at various procedural stages, relating to the outbreak. In July 2014, the Nevada Supreme Court held that claims brought by Medicare Advantage plan members are preempted by the Medicare Act, which the Company anticipates will result in the dismissal of seven of the individual lawsuits. The Company cannot reasonably estimate the range of loss, if any, that may result from these matters given the likelihood of reversal on appeal, the availability of statutory and other limits on damages, the novel legal theories being advanced by the plaintiffs, the various postures of the remaining cases, the availability in many cases of federal defenses under Medicare law and the Employee Retirement Income Security Act of 1974, and the pendency of certain relevant legal questions before the Nevada Supreme Court. The Company is vigorously defending these lawsuits.

Government Investigations, Audits and Reviews

The Company has been involved or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, the Brazilian national regulatory agency for private health insurance and plans (the Agência Nacional de Saúde Suplementar), state attorneys general, the Office of the Inspector General, the Office of Personnel Management, the Office of Civil Rights, the Government Accountability Office, the Federal Trade Commission, U.S. Congressional committees, the U.S. Department of Justice, the SEC, the Internal Revenue Service, the Brazilian federal revenue service (the Secretaria da Receita Federal), the U.S. Department of Labor, the Federal Deposit Insurance Corporation, the Defense Contract Audit Agency and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

In February 2012, CMS announced a final Risk Adjustment Data Validation (RADV) audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

The Company cannot reasonably estimate the range of loss, if any, that may result from any material government investigations, audits and reviews in which it is currently involved given the inherent difficulty in predicting regulatory action, fines and penalties, if any, and the various remedies and levels of judicial review available to the Company in the event of an adverse finding.

10. Segment Financial Information

Factors used to determine the Company's reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information presented to the Company's chief operating decision maker to evaluate its results of operations. Reportable segments with similar economic characteristics are combined. The Company's four reportable segments are UnitedHealthcare, OptumHealth, OptumInsight and OptumRx.

Transactions between reportable segments principally consist of sales of pharmacy benefit products and services to UnitedHealthcare customers by OptumRx, certain product offerings and care management and integrated care delivery services sold to UnitedHealthcare by OptumHealth, and health information and technology solutions, consulting and other services sold to UnitedHealthcare by OptumInsight. These transactions are recorded at management's estimate of fair value. Intersegment transactions are eliminated in consolidation. Corporate and intersegment elimination amounts are presented to reconcile the reportable segment results to the consolidated results. For more information on the Company's segments see Part I, Item I, "Business" and Note 13 of Notes to the Consolidated Financial Statements in Item II, Part 8, "Financial Statements" in the Company's 2013 10-K.

Prior period reportable segment financial information has been recast to conform to the 2014 presentation as discussed in Note 1. The following table presents the reportable segment financial information:

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
Three Months Ended September 30, 2014								
Revenues — external customers:								
Premiums	$ 28,287	$ 685	$ —	$ —	$ —	$ 685	$ —	$ 28,972
Services	1,617	373	521	24	—	918	—	2,535
Products	—	6	23	1,051	—	1,080	—	1,080
Total revenues — external customers	29,904	1,064	544	1,075	—	2,683	—	32,587
Total revenues — intersegment	—	1,749	705	6,936	(124)	9,266	(9,266)	—
Investment and other income	135	36	1	—	—	37	—	172
Total revenues	$ 30,039	$ 2,849	$ 1,250	$ 8,011	$ (124)	$ 11,986	$ (9,266)	$ 32,759
Earnings from operations	$ 2,038	$ 314	$ 225	$ 326	$ —	$ 865	$ —	$ 2,903
Interest expense	—	—	—	—	—	—	(152)	(152)
Earnings before income taxes	$ 2,038	$ 314	$ 225	$ 326	$ —	$ 865	$ (152)	$ 2,751
Three Months Ended September 30, 2013								
Revenues — external customers:								
Premiums	$ 26,698	$ 658	$ —	$ —	$ —	$ 658	$ —	$ 27,356
Services	1,554	193	509	24	—	726	—	2,280
Products	2	4	22	797	—	823	—	825
Total revenues — external customers	28,254	855	531	821	—	2,207	—	30,461
Total revenues — intersegment	—	1,607	670	5,474	(118)	7,633	(7,633)	—
Investment and other income	130	32	1	—	—	33	—	163
Total revenues	$ 28,384	$ 2,494	$ 1,202	$ 6,295	$ (118)	$ 9,873	$ (7,633)	$ 30,624
Earnings from operations	$ 1,950	$ 271	$ 212	$ 198	$ —	$ 681	$ —	$ 2,631
Interest expense	—	—	—	—	—	—	(178)	(178)
Earnings before income taxes	$ 1,950	$ 271	$ 212	$ 198	$ —	$ 681	$ (178)	$ 2,453

(in millions)	UnitedHealthcare	Optum					Corporate and Eliminations	Consolidated
		OptumHealth	OptumInsight	OptumRx	Optum Eliminations	Optum		
Nine Months Ended September 30, 2014								
Revenues — external customers:								
Premiums	$ 84,011	$ 1,916	$ —	$ —	$ —	$ 1,916	$ —	$ 85,927
Services	4,849	878	1,578	81	—	2,537	—	7,386
Products	2	17	63	3,033	—	3,113	—	3,115
Total revenues — external customers	88,862	2,811	1,641	3,114	—	7,566	—	96,428
Total revenues — intersegment	—	5,094	2,098	20,355	(354)	27,193	(27,193)	—
Investment and other income	502	110	1	—	—	111	—	613
Total revenues	$ 89,364	$ 8,015	$ 3,740	$ 23,469	$ (354)	$ 34,870	$ (27,193)	$ 97,041
Earnings from operations	$ 5,266	$ 749	$ 635	$ 859	$ —	$ 2,243	$ —	$ 7,509
Interest expense	—	—	—	—	—	—	(467)	(467)
Earnings before income taxes	$ 5,266	$ 749	$ 635	$ 859	$ —	$ 2,243	$ (467)	$ 7,042
Nine Months Ended September 30, 2013								
Revenues — external customers:								
Premiums	$ 79,982	$ 1,868	$ —	$ —	$ —	$ 1,868	$ —	$ 81,850
Services	4,485	576	1,504	71	—	2,151	—	6,636
Products	6	14	55	2,250	—	2,319	—	2,325
Total revenues — external customers	84,473	2,458	1,559	2,321	—	6,338	—	90,811
Total revenues — intersegment	—	4,795	1,976	14,817	(341)	21,247	(21,247)	—
Investment and other income	466	94	1	—	—	95	—	561
Total revenues	$ 84,939	$ 7,347	$ 3,536	$ 17,138	$ (341)	$ 27,680	$ (21,247)	$ 91,372
Earnings from operations	$ 5,357	$ 707	$ 650	$ 457	$ —	$ 1,814	$ —	$ 7,171
Interest expense	—	—	—	—	—	—	(532)	(532)
Earnings before income taxes	$ 5,357	$ 707	$ 650	$ 457	$ —	$ 1,814	$ (532)	$ 6,639

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion should be read together with the accompanying Condensed Consolidated Financial Statements and Notes and with our 2013 10-K, including the Consolidated Financial Statements and Notes in Item II, Part 8, "Financial Statements" in that report. References to the terms "UnitedHealth Group," "we," "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations refer to UnitedHealth Group Incorporated and its consolidated subsidiaries.

Readers are cautioned that the statements, estimates, projections or outlook contained in this Management's Discussion and Analysis of Financial Condition and Results of Operations, including discussions regarding financial prospects, economic conditions, trends and uncertainties contained in this Item 2, may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (PSLRA). These forward-looking statements involve risks and uncertainties that may cause our actual results to differ materially from the results discussed or implied in the forward-looking statements. A description of some of the risks and uncertainties is set forth in Part I, Item 1A, "Risk Factors" in our 2013 10-K and in the discussion below.

EXECUTIVE OVERVIEW

General

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making health care work better. We offer a broad spectrum of products and services through two distinct platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services.

Further information on our business is included in Part I, Item 1, "Business" in our 2013 10-K and additional information on our segments can be found in this Item 2 and in Note 10 of Notes to the Condensed Consolidated Financial Statements in Part I, Item 1 of this report.

Business Trends

Our businesses participate in the U.S., Brazilian and certain other international health economies. In the United States, health care spending comprises approximately 18% of gross domestic product and has grown consistently for many years. We expect overall spending on health care to continue to grow in the future, due to inflation, medical technology and pharmaceutical advancement, regulatory requirements, demographic trends in the population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and regulatory changes, including enacted health care reforms in the United States, which have impacted and could further impact our results of operations.

Pricing Trends. We seek to price our health care benefit products consistent with anticipated underlying medical trends, while balancing growth, margins, and competitive dynamics (such as product positioning and price competitiveness) and legislative and regulatory changes (such as cost increases for the Industry Tax provisions of Health Reform Legislation). Overall, we continue to be under pressure from ongoing market competition in commercial products and from government payment rates.

The intensity of commercial pricing competition depends on local market conditions and competitive dynamics. Health plans have generally reflected the 2014 Industry Tax and Reinsurance Programs (together, ACA Fees) in their pricing. Conversely, the industry has experienced lower medical cost trends due to moderated utilization, which has impacted pricing trends. We have seen intensified competitive pricing in several local markets recently, including for small group customers in a large market for us. If these trends continue, we could see further declines in commercial, off exchange risk-based membership.

Annual commercial premium rate increases are subject to federal and state review and approval procedures. While our rates and rate filings are developed using methods consistent with the standards of actuarial practice, we have experienced regulatory challenges to proposed premium rate increases in certain states, including California and New York.

The Medicare Advantage rate structure is changing and funding has been cut in recent years, including in 2014, with additional reductions to take effect in 2015, as discussed below in "Regulatory Trends and Uncertainties." We are taking actions to respond to these funding reductions, but the reductions have adversely affected after-tax earnings for our Medicare business during the first three quarters of 2014, an impact that we expect will continue during the balance of 2014 and into 2015.

Although we expect continued Medicaid revenue increases due to anticipated growth in our offerings, we also believe that the reimbursement rate environment creates the risk of downward pressure on Medicaid net margin percentages. We continue to work with our state customers to advocate for actuarially sound rates that are commensurate with our medical cost trends, including fees and related taxes, and to take a prudent, market-sustainable posture for both new bids and maintenance of existing Medicaid contracts.

Medical Cost Trends. Our medical cost trends are primarily related to unit costs, utilization and prescription drug costs. Consistent with our experience in recent years, our 2014 cost trends are largely driven by continued unit cost pressure from health care providers. Although the weak economic environment combined with our medical cost management strategies has had a favorable impact on utilization trends in recent years, the impact of Health Reform Legislation and mandates in 2014 is exerting upward pressure on medical cost trends. Driving the increases are mandated essential health benefits and limits on out-of-pocket maximums. The primary drivers of prescription drug trends continue to be unit cost pressure on brand name drugs and a shift towards expensive new specialty medications, including new hepatitis C therapies.

Delivery System and Payment Modernization. The health care market is changing based on demographic shifts, new regulations, political forces and both payer and patient expectations. Health plans and care providers are being called upon to work together to close gaps in care and enhance overall care for people, improve the health of populations and reduce costs. Delivery system modernization and payment reform are critical and the alignment of incentives between key constituents remains an important theme.

We are increasingly rewarding care providers for delivering improvements in quality and cost-efficiency. As of September 30, 2014, we served nearly 3 million people through the most progressive of these arrangements, including full-risk, shared-risk and bundled episode-of-care payment approaches. As of September 30, 2014, our contracts with value based spending total nearly $35 billion annually, up significantly from recent years.

This trend is creating needs for health management services that can coordinate care around the primary care physician, including new primary care channels, and for investments in new clinical and administrative information and management systems, which we believe will provide growth opportunities for our Optum business platform.

Regulatory Trends and Uncertainties

Following is a summary of management's view of the trends and uncertainties related to some of the key provisions of Health Reform Legislation and other regulatory items. For additional information regarding Health Reform Legislation and regulatory trends and uncertainties, see Part I, Item 1 "Business — Government Regulation" and Item 1A, "Risk Factors" in our 2013 10-K.

Medicare Advantage Rates and Minimum Loss Ratios. Medicare Advantage rates have been cut over the last several years, including in 2014, with additional funding reductions to be phased-in through 2017 as a result of (a) changes to CMS Medicare Advantage benchmark rates; (b) Health Reform Legislation; and (c) the Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012, which reduced Medicare

Advantage and Medicare Part D payments, beginning April 1, 2013 (Sequestration). The CMS final notice of 2015 Medicare Advantage benchmark rates and payment policies includes additional significant reductions for 2015. These industry level reductions, including the impact of the Industry Tax described below, are expected to result in revenue reductions and incremental assessments totaling more than 6% of revenue in 2014 and more than an additional 3% in 2015, against a typical industry forward medical cost trend of 3%. The impact of these cuts to our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements for those care providers with rates indexed to Medicare Advantage revenues or Medicare fee-for-service reimbursement rates. Compared to 2013, and prior to any efforts to mitigate these funding reductions, we estimate that the net impact of these reductions and the Industry Tax on our full-year 2014 consolidated net earnings will be more than $1.3 billion. These factors affected our plan benefit designs, market participation, growth prospects and earnings for our Medicare Advantage plans in 2014. Although, since the beginning of 2014, Medicare Advantage and Medicare Part D plans have been required to have minimum medical loss ratios (MLRs) of 85%, the minimum MLR standard has not had a material impact on our consolidated financial results.

Health Reform Legislation directed HHS to establish a program to reward high-quality Medicare Advantage plans beginning in 2012. Our Medicare Advantage rates are currently enhanced by CMS quality bonuses in certain counties based on our local plans' star ratings. The level of star ratings from CMS, based upon specified clinical and operational performance standards, will impact future quality bonuses. In addition, star ratings affect the amount of savings a plan has to generate to offer supplemental benefits, which ultimately may affect the plan's membership and revenue. The current expanded star bonus program that pays bonuses to qualifying plans rated 3 stars or higher expires after 2014. In 2015, quality bonus payments will be paid only to 4 and 5 star plans. For the 2015 payment year, we expect more than 37% of our Medicare Advantage members to be enrolled in plans that will be rated 4 stars or higher. We currently expect a similar percentage of members to be enrolled in such plans for the 2016 payment year. We are dedicating substantial resources to advance our quality scores and star ratings to strengthen our local market programs and further improve our performance for the 2017 and 2018 payment years.

The ongoing reductions to Medicare Advantage funding place continued importance on effective medical management and ongoing improvements in administrative efficiency. There are a number of adjustments we have made to partially offset these rate reductions. These adjustments will impact the majority of the seniors we serve through Medicare Advantage. For example, we seek to intensify our medical and operating cost management, make changes to the size and composition of our care provider networks, adjust members' benefits, implement or increase member premiums over and above the monthly payments we receive from the government, and decide on a county-by-county basis where we will offer Medicare Advantage plans. The depth of the underfunding of these benefits caused us to exit certain plans and market areas for 2014. In other markets, we may experience a reduction in membership in the plans with the greatest changes to premiums and benefits, but we expect stable or growing membership in our strongest markets.

In the longer term, we also may be able to mitigate some of the effects of reduced funding by increasing enrollment due, in part, to the increasing number of people eligible for Medicare in coming years. As Medicare Advantage reimbursement changes, other products may become relatively more attractive to Medicare beneficiaries increasing the demand for other senior health benefits products such as our market-leading Medicare Supplement and stand-alone Medicare Part D insurance offerings.

Industry Tax and Premium Stabilization Programs. Health Reform Legislation includes an Industry Tax levied proportionally across the health insurance industry for risk-based products, which began January 1, 2014. The industry-wide amount of the annual tax is $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in 2017 and $14.3 billion in 2018. For 2019 and beyond, the amount will equal the annual tax for the preceding year increased by the rate of premium growth for the preceding year.

With the introduction of state health insurance exchanges and other significant market reforms in the individual and small group markets in 2014, Health Reform Legislation includes three programs designed to stabilize the health insurance markets. These programs encompass: a Reinsurance Program; a temporary risk corridors

program; and a permanent risk adjustment program. The Reinsurance Program is a temporary program that will be funded on a per capita basis from all commercial lines of business including insured and self-funded arrangements. The total three year amount of $25 billion for the Reinsurance Program will be allocated as follows: $20 billion, subject to increases based on state decisions, to fund the reinsurance pool and $5 billion to fund the U.S. Treasury. While funding for the Reinsurance Program will come from all commercial lines of business, only market reform compliant individual business will be eligible for reinsurance recoveries.

In September 2014, we paid $1.3 billion for our share of the Industry Tax, which we began expensing ratably throughout the year on January 1, 2014. Because this tax is not deductible, we estimate a significant increase of approximately 500 basis points (bps) in our 2014 effective income tax rate. We estimate that the full-year 2014 expense from tax deductible contributions to the Reinsurance Program will be approximately $0.5 billion in 2014, payable in 2015. We do not expect material payments or receipts related to the temporary risk corridors program, permanent risk adjustment program or reinsurance recoveries in 2014. To the extent possible, we include the reform fees and related tax impacts in our pricing, which is expected to result in approximately $1.5 billion of additional annual premiums in 2014. Since the ACA Fees are included in operating costs, we expect our medical care ratio to decrease in 2014 compared to historical results; the cost of these fees is factored in, however, when calculating minimum MLR rebates. For detail on the Industry Tax and Premium Stabilization Programs, see Note 1 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Exchanges and Coverage Expansion. Across markets, we and our competitors are adapting product, network and marketing strategies to anticipate new or expanding distribution channels including public exchanges, private exchanges and off exchange purchasing. Effective in 2014, states have either created their own public exchange, entered a partnership exchange or relied on the federally facilitated exchange for individuals and small employers. The exchanges have created new market dynamics that have impacted and could further impact our existing businesses, depending on the ultimate member migration patterns for each market, the pace of migration in the market and the impact of the migration on our established membership. For example, over time certain employers may no longer offer health benefits to their employees and some employers purchasing full-risk products could convert to self-funded programs. Conversely, in private exchanges, some employers may convert from self-funded programs to full-risk products. Our level of participation in public exchanges is determined on a state-by-state basis. Each state is evaluated based on factors such as growth opportunities, our current local presence, our competitive positioning, our ability to honor our commitments to our local customers and consumers, and the regulatory environment. In 2014, we are participating in 13 exchanges, including four individual and nine small group exchanges. In 2015, we plan to participate in nearly two dozen individual exchanges and in 12 small group exchanges.

Health Reform Legislation, as interpreted by the U.S. Supreme Court, also provides for optional expanded Medicaid coverage that became effective in January 2014. We participate in programs in 24 states and the District of Columbia, and of these, 12 states opted to expand Medicaid for 2014. The Congressional Budget Office forecasts that 12 million people will obtain coverage through Medicaid by the end of 2016, and we endeavor to build market share serving the needs of these beneficiaries and their state sponsors.

Individual and Small Group Market Reforms. Health Reform Legislation includes several provisions, for most individual and small group plans with plan years that began on January 1, 2014, that have altered the individual and small group marketplace, including, among other matters: (a) adjusted community rating requirements, which change how individual and small group plans are priced in many states; (b) essential health benefit requirements that result in benefit changes for many individual and small group policyholders; (c) actuarial value requirements, which significantly impact benefit designs in the individual market, such as member cost sharing requirements; and (d) guaranteed issue requirements that obligate carriers to provide coverage to any qualified group or individual. These changes resulted in significant benefit design and pricing changes for a substantial portion of the fully insured individual and small group markets and a reduction in the number of states in which we offer policies to new individual customers. Additionally, states were granted the authority to allow eligible individuals and small businesses to renew non-ACA compliant plans, in some cases through October 2017.

RESULTS SUMMARY

The following table summarizes our consolidated results of operations and other financial information:

(in millions, except percentages and per share data)	Three Months Ended September 30, 2014	Three Months Ended September 30, 2013	Increase/ (Decrease) 2014 vs. 2013		Nine Months Ended September 30, 2014	Nine Months Ended September 30, 2013	Increase/ (Decrease) 2014 vs. 2013	
Revenues:								
Premiums	$ 28,972	$ 27,356	$ 1,616	6%	$ 85,927	$ 81,850	$ 4,077	5%
Services	2,535	2,280	255	11	7,386	6,636	750	11
Products	1,080	825	255	31	3,115	2,325	790	34
Investment and other income	172	163	9	6	613	561	52	9
Total revenues	32,759	30,624	2,135	7	97,041	91,372	5,669	6
Operating costs:								
Medical costs	23,092	22,044	1,048	5	69,823	66,786	3,037	5
Operating costs	5,436	4,869	567	12	15,836	14,308	1,528	11
Cost of products sold	955	731	224	31	2,776	2,082	694	33
Depreciation and amortization	373	349	24	7	1,097	1,025	72	7
Total operating costs	29,856	27,993	1,863	7	89,532	84,201	5,331	6
Earnings from operations	2,903	2,631	272	10	7,509	7,171	338	5
Interest expense	(152)	(178)	(26)	(15)	(467)	(532)	(65)	(12)
Earnings before income taxes	2,751	2,453	298	12	7,042	6,639	403	6
Provision for income taxes	(1,149)	(883)	266	30	(2,933)	(2,393)	540	23
Net earnings	1,602	1,570	32	2	4,109	4,246	(137)	(3)
Earnings attributable to noncontrolling interests	—	—	—	nm	—	(48)	(48)	nm
Net earnings attributable to UnitedHealth Group common shareholders	$ 1,602	$ 1,570	$ 32	2%	$ 4,109	$ 4,198	$ (89)	(2)%
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$ 1.63	$ 1.53	$ 0.10	7%	$ 4.15	$ 4.09	$ 0.06	1%
Medical care ratio (a)	79.7%	80.6%	(0.9)%		81.3%	81.6%	(0.3)%	
Operating cost ratio	16.6	15.9	0.7		16.3	15.7	0.6	
Operating margin	8.9	8.6	0.3		7.7	7.8	(0.1)	
Tax rate	41.8	36.0	5.8		41.7	36.0	5.7	
Net earnings margin	4.9	5.1	(0.2)		4.2	4.6	(0.4)	
Return on equity (b)	19.6%	19.8%	(0.2)%		16.8%	17.7%	(0.9)%	

nm= not meaningful

(a) Medical care ratio is calculated as medical costs divided by premium revenue.

(b) Return on equity is calculated as annualized net earnings divided by average equity. Average equity is calculated using the equity balance at the end of the preceding year and the equity balances at the end of each of the quarters in the periods presented.

SELECTED OPERATING PERFORMANCE AND OTHER SIGNIFICANT ITEMS

The following represents a summary of select third quarter 2014 year-over-year operating comparisons to 2013 and other 2014 significant items.

- Consolidated revenues increased by 7%, Optum revenues grew 21% and UnitedHealthcare revenues increased 6%.
- ACA Fees have favorably affected our 2014 medical care ratio (110 bps), and unfavorably impacted our operating cost ratio (120 bps) and effective income tax rate (5%).
- Earnings from operations increased by 10%, including an increase of 27% at Optum and 5% at UnitedHealthcare.
- Earnings per share to UnitedHealth Group shareholders increased 7% to $1.63 and included the negative year-over-year per share impact of $0.25 in ACA Fees, ACA Medicare rate cuts and other ACA impacts.
- As of September 30, 2014, there was $1.0 billion of cash available for general corporate use and year-to-date 2014 cash flows from operations were $5.6 billion.

2014 RESULTS OF OPERATIONS COMPARED TO 2013 RESULTS

Consolidated Financial Results

Revenues

The increases in revenues during the three and nine months ended September 30, 2014 were primarily driven by growth in the number of individuals served in our public and senior markets businesses and pharmacy services growth at Optum.

Medical Costs and Medical Care Ratio

Medical costs during the three and nine months ended September 30, 2014 increased due to risk-based membership growth in our public and senior markets businesses. The impact of billing the ACA Fees decreased the medical care ratio for the three and nine months ended September 30, 2014 compared to 2013. The nine month medical care ratio decrease was partially offset by the impact of lower levels of favorable medical cost reserve development.

Operating Cost Ratio

The increase in our operating cost ratio during the three and nine months ended September 30, 2014 was due to the introduction of ACA Fees and specific investments in Optum growth platforms, partially offset by productivity and operating performance gains.

Income Tax Rate

The increase in our income tax rate resulted primarily from the nondeductible Industry Tax.

See Note 1 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1, and "Industry Tax and Premium Stabilization Programs" in the "Executive Overview" above for more information on ACA Fees.

Reportable Segments

Prior period segment financial information has been recast to conform to the 2014 presentation. See Notes 1 and 10 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report for more information on our segments. The following table presents a summary of the reportable segment financial information:

(in millions, except percentages)	Three Months Ended September 30, 2014	2013	Increase/(Decrease) 2014 vs. 2013		Nine Months Ended September 30, 2014	2013	Increase/(Decrease) 2014 vs. 2013	
Revenues								
UnitedHealthcare	$ 30,039	$ 28,384	$ 1,655	6%	$ 89,364	$ 84,939	$ 4,425	5%
OptumHealth	2,849	2,494	355	14	8,015	7,347	668	9
OptumInsight	1,250	1,202	48	4	3,740	3,536	204	6
OptumRx	8,011	6,295	1,716	27	23,469	17,138	6,331	37
Optum eliminations	(124)	(118)	6	5	(354)	(341)	13	4
Optum	11,986	9,873	2,113	21	34,870	27,680	7,190	26
Eliminations	(9,266)	(7,633)	1,633	21	(27,193)	(21,247)	5,946	28
Consolidated revenues	$ 32,759	$ 30,624	$ 2,135	7%	$ 97,041	$ 91,372	$ 5,669	6%
Earnings from operations								
UnitedHealthcare	$ 2,038	$ 1,950	$ 88	5%	$ 5,266	$ 5,357	$ (91)	(2)%
OptumHealth	314	271	43	16	749	707	42	6
OptumInsight	225	212	13	6	635	650	(15)	(2)
OptumRx	326	198	128	65	859	457	402	88
Optum	865	681	184	27	2,243	1,814	429	24
Consolidated earnings from operations	$ 2,903	$ 2,631	$ 272	10%	$ 7,509	$ 7,171	$ 338	5%
Operating margin								
UnitedHealthcare	6.8%	6.9%	(0.1)%		5.9%	6.3%	(0.4)%	
OptumHealth	11.0	10.9	0.1		9.3	9.6	(0.3)	
OptumInsight	18.0	17.6	0.4		17.0	18.4	(1.4)	
OptumRx	4.1	3.1	1.0		3.7	2.7	1.0	
Optum	7.2	6.9	0.3		6.4	6.6	(0.2)	
Consolidated operating margin	8.9%	8.6%	0.3%		7.7%	7.8%	(0.1)%	

UnitedHealthcare

The following table summarizes UnitedHealthcare revenue by business:

(in millions, except percentages)	Three Months Ended September 30, 2014	2013	Increase/(Decrease) 2014 vs. 2013		Nine Months Ended September 30, 2014	2013	Increase/(Decrease) 2014 vs. 2013	
UnitedHealthcare Employer & Individual	$ 10,610	$ 11,230	$ (620)	(6)%	$ 32,296	$ 33,424	$ (1,128)	(3)%
UnitedHealthcare Medicare & Retirement	11,477	11,042	435	4	34,764	33,275	1,489	4
UnitedHealthcare Community & State	6,131	4,581	1,550	34	17,069	13,501	3,568	26
UnitedHealthcare International	1,821	1,531	290	19	5,235	4,739	496	10
Total UnitedHealthcare revenue	$ 30,039	$ 28,384	$ 1,655	6%	$ 89,364	$ 84,939	$ 4,425	5%

The following table summarizes the number of individuals served by our UnitedHealthcare businesses, by major market segment and funding arrangement:

(in thousands, except percentages)	September 30, 2014	September 30, 2013	Increase/(Decrease) 2014 vs. 2013	
Commercial risk-based	7,545	8,130	(585)	(7)%
Commercial fee-based	18,300	19,060	(760)	(4)
Commercial fee-based TRICARE	2,910	2,930	(20)	(1)
Total commercial	28,755	30,120	(1,365)	(5)
Medicare Advantage	2,995	2,970	25	1
Medicaid	4,920	3,955	965	24
Medicare Supplement (Standardized)	3,715	3,415	300	9
Total public and senior	11,630	10,340	1,290	12
International	4,550	4,815	(265)	(6)
Total UnitedHealthcare — medical	44,935	45,275	(340)	(1)%
Supplemental Data:				
Medicare Part D stand-alone	5,155	4,895	260	5%

The decrease in commercial risk-based enrollment was a result of disciplined pricing in a continued competitive environment and a decrease in individual policy customers due in part to customers moving to public exchanges. The decrease in number of people served under commercial fee-based arrangements was primarily due to the loss of a large state employer account. Medicare Advantage participation increased year-over-year despite the significant funding reductions, which caused us to exit certain markets in January 2014, reduce product offerings, adjust networks and reduce benefits for 2014. Nearly 60% of the Medicaid growth was driven by Medicaid expansion under the ACA with the remaining growth from the combination of states launching new programs to complement established programs and market approaches and growth in those traditional programs. Medicare Supplement growth reflected strong customer retention and new sales. The number of people served internationally decreased year-over-year primarily due to price increases in Brazil in response to the increasing costs of mandated health care benefits. In our Medicare Part D stand-alone business, the number of people served increased primarily as a result of new product introductions and strong customer retention in the market.

UnitedHealthcare's revenue growth during the three and nine months ended September 30, 2014 was due to growth in the number of individuals served in our public and senior markets businesses, revenues to recover ACA Fees and commercial price increases reflecting underlying medical cost trends, partially offset by decreased commercial risk-based enrollment and a reduced level of Medicare Advantage funding.

UnitedHealthcare's operating earnings for the three and nine months ended September 30, 2014 were pressured year-over-year by ACA Fees, Medicare Advantage funding reductions and increased spending on specialty medications to treat hepatitis C. Offsetting these factors were public and senior growth, reduced levels of per-member inpatient hospital utilization and revenue true-ups. For the nine month period, operating earnings were also impacted by reduced levels of favorable medical cost reserve development compared to 2013.

Optum

Total revenues increased for the three and nine months ended September 30, 2014 primarily due to pharmacy growth at OptumRx and growth at OptumHealth.

The increases in Optum's earnings from operations for the three and nine months ended September 30, 2014 were driven by earnings growth at OptumRx and OptumHealth. Optum's operating margin improved for the three months ended September 30, 2014 primarily as a result of enhanced margin performance at OptumRx. The

operating margin declined for the nine months ended September 30, 2014 due to the increased mix of comparatively lower margin pharmacy services in Optum's overall business and investments to develop future growth opportunities, particularly at OptumHealth and OptumInsight.

The results by segment were as follows:

OptumHealth

Revenue increased at OptumHealth for the three and nine months ended September 30, 2014 primarily due to expansion and growth in integrated care delivery services.

Earnings from operations for the three and nine months ended September 30, 2014 increased primarily due to revenue growth and cost efficiencies, offset in part by investments to develop future growth opportunities.

The operating margin for the nine months ended September 30, 2014 decreased slightly due to investments for future growth.

OptumInsight

Revenue at OptumInsight for the three and nine months ended September 30, 2014 increased primarily due to the growth in Optum360 revenue management and government exchange services, partially offset by a reduction in hospital compliance services.

Earnings from operations and operating margins for the three and nine months ended September 30, 2014 reflected changes in product mix and investments for future growth.

OptumRx

Increased OptumRx revenue for the three and nine months ended September 30, 2014 was due to growth in people served in UnitedHealthcare's public and senior markets, the insourcing of UnitedHealthcare's commercial pharmacy benefit programs, growth from external clients as well as an increase in specialty pharmaceutical revenues.

Earnings from operations and operating margins for the three and nine months ended September 30, 2014 increased primarily due to growth in scale that resulted in greater productivity and better absorption of our fixed costs, and improved performance in both drug purchasing and mail fulfillment.

LIQUIDITY, FINANCIAL CONDITION AND CAPITAL RESOURCES

Liquidity

Introduction

We manage our liquidity and financial position in the context of our overall business strategy. We continually forecast and manage our cash, investments, working capital balances and capital structure to meet the short-term and long-term obligations of our businesses while seeking to maintain liquidity and financial flexibility. Cash flows generated from operating activities are principally from earnings before noncash expenses.

Our regulated subsidiaries generate significant cash flows from operations and are subject to financial regulations and standards in their respective jurisdictions. These standards, among other things, require these subsidiaries to maintain specified levels of statutory capital, as defined by each jurisdiction, and restrict the timing and amount of dividends and other distributions that may be paid to their parent companies. In the United States, most of these regulations and standards are generally consistent with model regulations established by the National

Association of Insurance Commissioners. Except in the case of extraordinary dividends, these standards generally permit dividends to be paid from statutory unassigned surplus of the regulated subsidiary and are limited based on the regulated subsidiary's level of statutory net income and statutory capital and surplus. These dividends are referred to as "ordinary dividends" and generally may be paid without prior regulatory approval. If the dividend, together with other dividends paid within the preceding twelve months, exceeds a specified statutory limit or is paid from sources other than earned surplus, the entire dividend is generally considered an "extraordinary dividend" and must receive prior regulatory approval.

For the nine months ended September 30, 2014, our U.S. regulated subsidiaries paid their parent companies dividends of $3.8 billion, and we had approximately $1.3 billion in ordinary dividend capacity remaining. For the twelve months ended December 31, 2013, our regulated subsidiaries paid their parent companies dividends of $3.2 billion.

Our nonregulated businesses also generate cash flows from operations that are available for general corporate use. Cash flows generated by these entities, combined with dividends from our regulated entities and financing through the issuance of long-term debt as well as issuance of commercial paper or the ability to draw under our committed credit facilities, further strengthen our operating and financial flexibility. We use these cash flows to expand our businesses through acquisitions, reinvest in our businesses through capital expenditures, repay debt, and return capital to our shareholders through shareholder dividends and/or repurchases of our common stock, depending on market conditions.

Summary of our Major Sources and Uses of Cash and Cash Equivalents

	Nine Months Ended September 30,		Increase/ (Decrease)
(in millions)	**2014**	**2013**	**2014 vs. 2013**
Sources of cash:			
Cash provided by operating activities	$ 5,622	$ 5,923	$ (301)
Sales and maturities of investments, net of purchases	253	—	253
Customer funds administered	—	308	(308)
Proceeds from common stock issuances	400	538	(138)
Issuances of long-term debt and commercial paper, net of repayments	543	146	397
Other	—	45	(45)
Total sources of cash	6,818	6,960	
Uses of cash:			
Common stock repurchases	(3,024)	(2,348)	(676)
Purchases of property, equipment and capitalized software, net	(1,121)	(840)	(281)
Cash dividends paid	(1,004)	(777)	(227)
Cash paid for acquisitions and noncontrolling interest shares, net of cash assumed	(851)	(1,804)	953
Purchases of investments, net of sales and maturities	—	(1,148)	1,148
Customer funds administered	(440)	—	(440)
Other	(424)	(76)	(348)
Total uses of cash	(6,864)	(6,993)	
Effect of exchange rate changes on cash and cash equivalents	3	(87)	90
Net decrease in cash and cash equivalents	$ (43)	$ (120)	$ 77

2014 Cash Flows Compared to 2013 Cash Flows

Cash flows provided by operating activities in 2014 decreased primarily due to the September payment of the $1.3 billion Industry Tax ahead of related fourth quarter customer collections and an increase in government receivables. These decreases were partially offset by an increased level of accounts payable and other liabilities from the collection of Reinsurance Program fees in advance of remittance in 2015, and an increase in accrued income taxes.

Other significant changes in sources or uses of cash year-over-year included: (a) a change in investment activity from net purchases in 2013 to net sales in 2014; (b) decreased spending on acquisitions and noncontrolling interest shares; (c) an increase in Part D subsidy receivables causing a change in customer funds administered; and (d) increased repurchases of common stock.

Financial Condition

As of September 30, 2014, our cash, cash equivalent and available-for-sale investment balances of $28.0 billion included $7.2 billion of cash and cash equivalents (of which $1.0 billion was available for general corporate use), $19.2 billion of debt securities and $1.6 billion of investments in equity securities consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Given the significant portion of our portfolio held in cash equivalents, we do not anticipate fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position. The use of different market assumptions or valuation methodologies, especially those used in valuing our $367 million of available-for-sale Level 3 securities (those securities priced using significant unobservable inputs), may have an effect on the estimated fair values of our investments. Due to the subjective nature of these assumptions, the estimates may not be indicative of the actual exit price if we had sold the investment at the measurement date. Other sources of liquidity, primarily from operating cash flows and our commercial paper program, which is supported by our bank credit facilities, reduce the need to sell investments during adverse market conditions. See Note 3 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report for further detail concerning our fair value measurements.

Our available-for-sale debt portfolio had a weighted-average duration of 3.4 years and a weighted-average credit rating of “AA” as of September 30, 2014. When multiple credit ratings are available for an individual security, the average of the available ratings is used to determine the weighted-average credit rating.

Capital Resources and Uses of Liquidity

In addition to cash flows from operations and cash and cash equivalent balances available for general corporate use, our capital resources and uses of liquidity are as follows:

Commercial Paper and Bank Credit Facilities. Our bank credit facilities provide liquidity support for our commercial paper borrowing program, which facilitates the private placement of unsecured debt through third-party broker-dealers, and are available for general corporate purposes. For more information on our commercial paper and bank credit facilities, see Note 6 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Our bank credit facilities contain various covenants, including covenants requiring us to maintain a debt to debt-plus-equity ratio of not more than 50%. Our debt to debt-plus-equity ratio, calculated as the sum of debt divided by the sum of debt and shareholders’ equity, which reasonably approximates the actual covenant ratio, was 34.9% as of September 30, 2014.

Long-term Debt. Periodically, we access capital markets and issue long-term debt for general corporate purposes, for example, to meet our working capital requirements, to refinance debt, to finance acquisitions or for share repurchases.

Credit Ratings. Our credit ratings as of September 30, 2014 were as follows:

	Moody's		Standard & Poor's		Fitch		A.M. Best	
	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook	Ratings	Outlook
Senior unsecured debt	A3	Stable	A	Positive	A-	Stable	bbb+	Stable
Commercial paper	P-2	n/a	A-1	n/a	F1	n/a	AMB-2	n/a

The availability of financing in the form of debt or equity is influenced by many factors, including our profitability, operating cash flows, debt levels, credit ratings, debt covenants and other contractual restrictions, regulatory requirements and economic and market conditions. For example, a significant downgrade in our credit ratings or adverse conditions in the capital markets may increase the cost of borrowing for us or limit our access to capital.

Share Repurchase Program. In June 2014, our Board renewed our share repurchase program with an authorization to repurchase up to 100 million shares of our common stock. As of September 30, 2014, we had Board authorization to purchase up to an additional 82 million shares of our common stock. For more information on our share repurchase program, see Note 7 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

Dividends. In June 2014, our Board of Directors increased our quarterly cash dividend to shareholders to an annual dividend rate of $1.50 per share. For more information on our dividend, see Note 7 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

CONTRACTUAL OBLIGATIONS AND COMMITMENTS

A summary of future obligations under our various contractual obligations and commitments as of December 31, 2013 was disclosed in our 2013 10-K. During the nine months ended September 30, 2014, there were no material changes to this previously disclosed information outside the ordinary course of business. However, we continually evaluate opportunities to expand our operations, including through internal development of new products, programs and technology applications and acquisitions.

RECENTLY ISSUED ACCOUNTING STANDARDS

In May 2014, the Financial Accounting Standards Board issued ASU No. 2014-09 "Revenue from Contracts with Customers (Topic 606)." ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard using either the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. We are currently evaluating the effect of the new revenue recognition guidance.

We have determined that there have been no other recently issued, but not yet adopted, accounting standards that will have a material impact on our Condensed Consolidated Financial Statements.

CRITICAL ACCOUNTING ESTIMATES

In preparing these Condensed Consolidated Financial Statements, we are required to make judgments, assumptions and estimates, which we believe are reasonable and prudent based on the available facts and circumstances. These judgments, assumptions and estimates affect certain of our revenues and expenses and their related balance sheet accounts and disclosure of our contingent liabilities. We base our assumptions and estimates primarily on historical

experience and factor in known and projected trends. On an ongoing basis, we re-evaluate our selection of assumptions and the method of calculating our estimates. Actual results, however, may materially differ from our calculated estimates and this difference would be reported in our current operations.

Our critical accounting estimates include medical costs payable, revenues, goodwill and intangible assets, investments, income taxes and contingent liabilities. For a detailed description of our critical accounting estimates, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 of our 2013 10-K. For a detailed discussion of our significant accounting policies, see Note 2 of Notes to the Consolidated Financial Statements in Item II, Part 8, "Financial Statements" in our 2013 10-K and Note 1 of Notes to the Condensed Consolidated Financial Statements included in Part I, Item 1 of this report.

FORWARD-LOOKING STATEMENTS

The statements, estimates, projections, guidance or outlook contained in this report include "forward-looking" statements within the meaning of the PSLRA. These statements are intended to take advantage of the "safe harbor" provisions of the PSLRA. Generally, the words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "plan," "project," "should" and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties. We caution that actual results could differ materially from those that management expects, depending on the outcome of certain factors.

Some factors that could cause results to differ materially from results discussed or implied in the forward-looking statements include: our ability to effectively estimate, price for and manage our medical costs, including the impact of any new coverage requirements; the potential impact that new laws or regulations, or changes in existing laws or regulations, or their enforcement or application could have on our results of operations, financial position and cash flows, including as a result of increases in medical, administrative, technology or other costs or decreases in enrollment resulting from U.S., Brazilian and other jurisdictions' regulations affecting the health care industry; the impact of any potential assessments for insolvent payers under state guaranty fund laws; the impact of the Patient Protection and Affordable Care Act, which could materially and adversely affect our results of operations, financial position and cash flows through reduced revenues, increased costs, new taxes and expanded liability, or require changes to the ways in which we conduct business or put us at risk for loss of business; potential reductions in revenue or delays to cash flows received under Medicare, Medicaid and TRICARE programs, including sequestration and potential effects of a prolonged U.S. government shutdown or debt ceiling constraints; uncertainties regarding changes in Medicare, including potential changes in risk adjustment data validation audit and payment adjustment methodology; failure to comply with privacy and data security regulations; regulatory and other risks and uncertainties associated with the pharmacy benefits management industry; competitive pressures, which could affect our ability to maintain or increase our market share; the impact of challenges to our public sector contract awards; our ability to execute contracts on competitive terms with physicians, hospitals and other service professionals; increases in costs and other liabilities associated with increased litigation, government investigations, audits or reviews; failure to manage successfully our strategic alliances or complete or receive anticipated benefits of acquisitions and other strategic transactions, including the Amil acquisition; the impact of fluctuations in foreign currency exchange rates on our reported shareholders' equity and results of operations; potential downgrades in our credit ratings; our ability to attract, retain and provide support to a network of independent producers (i.e., brokers and agents) and consultants; the potential impact of adverse economic conditions on our revenues (including decreases in enrollment resulting from increases in the unemployment rate and commercial attrition) and results of operations; the performance of our investment portfolio; possible impairment of the value of our goodwill and intangible assets in connection with dispositions or if estimated future results do not adequately support goodwill and intangible assets recorded for our existing businesses or the businesses that we acquire; increases in health care costs resulting from large-scale medical emergencies; failure to maintain effective and efficient information systems or if our technology products otherwise do not operate as intended; misappropriation of our proprietary technology; failure to protect against cyber-attacks or other privacy or data security incidents; our ability to obtain sufficient funds from our regulated subsidiaries or the debt or capital markets to fund our obligations, to

maintain our debt to total capital ratio at targeted levels, to maintain our quarterly dividend payment cycle or to continue repurchasing shares of our common stock; and failure to achieve targeted operating cost productivity improvements, including savings resulting from technology enhancement and administrative modernization.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain risk factors that may affect our business operations, financial condition and results of operations, in our other periodic and current filings with the SEC, including our 2013 10-K. Any or all forward-looking statements we make may turn out to be wrong, and can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual future results may vary materially from expectations expressed or implied in this report or any of our prior communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements, except as required by applicable securities laws.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our primary market risks are exposures to (a) changes in interest rates that impact our investment income and interest expense and the fair value of certain of our fixed-rate investments and debt, (b) foreign currency exchange rate risk of the U.S. dollar primarily to the Brazilian real and (c) changes in equity prices that impact the value of our equity investments.

As of September 30, 2014, we had $8.7 billion of cash, cash equivalents and investments on which the interest rates received vary with market interest rates, which may materially impact our investment income. Also, $9.9 billion of our commercial paper, debt and deposit liabilities as of September 30, 2014 were at interest rates that vary with market rates, either directly or through the use of related interest rate swap contracts.

The fair value of certain of our fixed-rate investments and debt also varies with market interest rates. As of September 30, 2014, $18.3 billion of our investments were fixed-rate debt securities and $10.2 billion of our debt was non-swapped fixed-rate term debt. An increase in market interest rates decreases the market value of fixed-rate investments and fixed-rate debt. Conversely, a decrease in market interest rates increases the market value of fixed-rate investments and fixed-rate debt.

We manage exposure to market interest rates by diversifying investments across different fixed income market sectors and debt across maturities, as well as by endeavoring to match our floating-rate assets and liabilities over time, either directly or through the use of interest rate swap contracts.

The following table summarizes the impact of hypothetical changes in market interest rates across the entire yield curve by 1% point or 2% points as of September 30, 2014 on our investment income and interest expense per annum, and the fair value of our investments and debt (in millions, except percentages):

	September 30, 2014			
Increase (Decrease) in Market Interest Rate	Investment Income Per Annum (a)	Interest Expense Per Annum (a)	Fair Value of Investments (b)	Fair Value of Debt
2%	$ 173	$ 195	$ (1,417)	$ (1,510)
1	87	98	(720)	(551)
(1)	(36)	(15)	689	1,983
(2)	nm	nm	1,252	2,747

nm = not meaningful

(a) Given the low absolute level of short-term market rates on our floating-rate assets and liabilities as of September 30, 2014, the assumed hypothetical change in interest rates does not reflect the full 100 basis point reduction in interest income or interest expense as the rate cannot fall below zero and thus the 200 basis point reduction is not meaningful.

(b) As of September 30, 2014, some of our investments had interest rates below 2% so the assumed hypothetical change in the fair value of investments does not reflect the full 200 basis point reduction.

We have an exposure to changes in the value of the Brazilian real to the U.S. dollar in translation of Amil's operating results at the average exchange rate over the accounting period, and Amil's assets and liabilities at the spot rate at the end of the accounting period. The gains or losses resulting from translating foreign currency assets and liabilities into U.S. dollars are included in shareholders' equity and comprehensive income.

An appreciation of the U.S. dollar against the Brazilian real reduces the carrying value of the net assets denominated in Brazilian real. For example, as of September 30, 2014, a hypothetical 10% and 20% increase in the value of the U.S. dollar against the Brazilian real would have caused a reduction in net assets of approximately $445 million and $815 million, respectively. We manage exposure to foreign currency risk by conducting our international business operations primarily in their functional currencies.

As of September 30, 2014, we had $1.6 billion of investments in equity securities, consisting of investments in non-U.S. dollar fixed-income funds; employee savings plan related investments; venture capital funds; and dividend paying stocks. Valuations in non-U.S. dollar funds are subject to foreign exchange rates. Valuations in venture capital funds are subject to conditions affecting health care and technology stocks, and dividend paying equities are subject to more general market conditions.

ITEM 4. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of September 30, 2014. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of September 30, 2014.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There have been no changes in our internal control over financial reporting during the quarter ended September 30, 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

A description of our legal proceedings is included in and incorporated by reference to Note 9 of Notes to the Condensed Consolidated Financial Statements contained in Part I, Item 1 of this report.

ITEM 1A. RISK FACTORS

In addition to the other information set forth in this report, you should carefully consider the factors discussed in Part I, Item 1A, "Risk Factors" of our 2013 10-K, which could materially affect our business, financial condition or future results. The risks described in our 2013 10-K are not the only risks facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely affect our business, financial condition and/or future results.

There have been no material changes to the risk factors disclosed in our 2013 10-K.

ITEM 2. UNREGISTERED SALE OF EQUITY SECURITIES AND USE OF PROCEEDS

Issuer Purchases of Equity Securities (a)
Third Quarter 2014

For the Month Ended	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May Yet Be Purchased Under The Plans or Programs
	(in millions)		(in millions)	(in millions)
July 31, 2014	3	$ 84	3	92
August 31, 2014	6	82	6	86
September 30, 2014	4	87	4	82
Total	13	$ 84	13	

(a) In November 1997, our Board of Directors adopted a share repurchase program, which the Board evaluates periodically. In June 2014, the Board renewed our share repurchase program with an authorization to repurchase up to 100 million shares of our common stock in open market purchases or other types of transactions (including prepaid or structured repurchase programs). There is no established expiration date for the program.

ITEM 6. EXHIBITS *

The following exhibits are filed in response to Item 601 of Regulation S-K.

3.1	Third Restated Articles of Incorporation of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated May 29, 2007)
3.2	Fourth Amended and Restated Bylaws of UnitedHealth Group Incorporated (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated October 23, 2009)
4.1	Senior Indenture, dated as of November 15, 1998, between United HealthCare Corporation and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3/A, SEC File Number 333-66013, filed on January 11, 1999)
4.2	Amendment, dated as of November 6, 2000, to Senior Indenture, dated as of November 15, 1998, between UnitedHealth Group Incorporated and The Bank of New York (incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2001)
4.3	Instrument of Resignation, Appointment and Acceptance of Trustee, dated January 8, 2007, pursuant to the Senior Indenture, dated as of November 15, 1998, amended November 6, 2000, among UnitedHealth Group Incorporated, The Bank of New York and Wilmington Trust Company (incorporated by reference to Exhibit 4.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007)
4.4	Indenture, dated as of February 4, 2008, between UnitedHealth Group Incorporated and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-3, SEC File Number 333-149031, filed on February 4, 2008)
10.1	Summary of Non-Management Director Compensation
10.2	Fifth Amendment to UnitedHealth Group Executive Savings Plan (2004 Statement)
12.1	Computation of Ratio of Earnings to Fixed Charges
31.1	Certifications pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certifications pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	The following materials from UnitedHealth Group Incorporated's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014 filed on November 10, 2014, formatted in XBRL (eXtensible Business Reporting Language): (i) Condensed Consolidated Balance Sheets, (ii) Condensed Consolidated Statements of Operations, (iii) Condensed Consolidated Statements of Comprehensive Income, (iv) Condensed Consolidated Statements of Changes in Shareholders' Equity, (v) Condensed Consolidated Statements of Cash Flows, and (vi) Notes to the Condensed Consolidated Financial Statements.

* Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

UNITEDHEALTH GROUP INCORPORATED

/s/ STEPHEN J. HEMSLEY **Stephen J. Hemsley**	President and Chief Executive Officer (principal executive officer)	Dated: November 10, 2014
/s/ DAVID S. WICHMANN **David S. Wichmann**	Executive Vice President and Chief Financial Officer of UnitedHealth Group and President of UnitedHealth Group Operations (principal financial officer)	Dated: November 10, 2014
/s/ ERIC S. RANGEN **Eric S. Rangen**	Senior Vice President and Chief Accounting Officer (principal accounting officer)	Dated: November 10, 2014

EXHIBIT INDEX*

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* Pursuant to Item 601(b)(4)(iii) of Regulation S-K, copies of instruments defining the rights of certain holders of long-term debt are not filed. The Company will furnish copies thereof to the SEC upon request.

Sample Implementation Timeline for the City of Hollywood, Florida
FI - VISION

Implementation Timeline

Proposed Effective Date : 04-01-2015

Ref #	Milestone	Responsible Party	Projected Date
1	Receive Sales Documents and Finalize Administrative Items	UHG	02-05-2015
2	Customer Implementation Meeting	UHG / Customer	02-07-2015
3	Submit Case for Quality Review	UHG	02-12-2015
4	Vision Product Ready	UHG	02-18-2015
5	Quality Review Completed	UHG	02-18-2015
6	Case Package submitted to Functional Areas	UHG	02-19-2015
7	Eligibility Structure Sent for Review & Approval	UHG	02-20-2015
8	Eligibility Structure Approved	UHG / Customer	02-21-2015
9	Final Eligibility Structure Released into Production	UHG	03-02-2015
10	Receive Eligibility File	Customer	03-04-2015
11	Eligibility File Uploaded	UHG	03-11-2015
12	Plan Documents Presented	UHG	03-05-2015
13	Plan Documents Approved	UHG / Customer	03-19-2015
14	First new billing statement released to customer	UHG	03-26-2015
15	Vision Ready	UHG	03-12-2015
16	Overall Ready	UHG	03-12-2015

Dates shown are for illustration purposes only. We will meet with you to set mutually agreeable dates based on your specific needs, including adjustments to accommodate shorter implementation periods if needed.

Better Information. Better Decisions. Better Health.

February 12, 2015

A Report on the Accessibility

UnitedHealthcare Spectera Vision Providers

for the employees of

City of Hollywood FL

Table of Contents

Accessibility Overview

Accessibility overview specifications

Employees	Access standard	Providers	Total number of employees	Total number of providers	All employees			
					With access		Without access	
					Number	Pct	Number	Pct
All Employees	1 in 10	All Vision Providers	2,390	58,421	2,335	97.7	55	2.3

GeoAccess®

Accessibility summary

Accessibility analysis specifications	
Provider group:	**All Vision Providers** 58,421 providers at 18,549 locations (based on 58,421 records)
Employee group:	**All Employees** 2,390 employees
Access standard:	**1 in 10**
Employees with desired access:	2,335 (97.7%)

Average distance to a choice of providers for employees with desired access

Number of providers	1	2	3	4	5
Miles	1.3	1.8	2.1	2.3	2.6

Key geographic areas

City	Total number of employees	Employees with desired access		
		Number	Percent	Average distance to 1 provider
HOLLYWOOD, FL	923	923	100.0	0.7
FORT LAUDERDALE, FL	551	551	100.0	0.9
MIAMI, FL	112	112	100.0	0.9
POMPANO BEACH, FL	100	100	100.0	0.9
DANIA, FL	32	32	100.0	0.6
HALLANDALE, FL	32	32	100.0	0.6
PEMBROKE PINES, FL	30	30	100.0	0.8
HIALEAH, FL	27	27	100.0	0.6
BOCA RATON, FL	24	24	100.0	1.0
PORT SAINT LUCIE, FL	23	23	100.0	2.1

GeoAccess®

Accessibility summary

Accessibility analysis specifications	
Provider group:	**All Vision Providers** 58,421 providers at 18,549 locations (based on 58,421 records)
Employee group:	**All Employees** 2,390 employees
Access standard:	**1 in 10**
Employees without desired access:	55 (2.3%)

Average distance to a choice of providers for employees without desired access

Number of providers	1	2	3	4	5
Miles	16.3	20.4	22.0	22.9	23.7

Key geographic areas

City	Total number of employees	Employees without desired access		
		Number	Percent	Average distance to 1 provider
DUNLAP, TN	7	7	100.0	14.7
TAVERNIER, FL	3	3	100.0	12.5
BASCOM, FL	2	2	100.0	27.0
LOXAHATCHEE, FL	18	1	5.6	11.0
SAINT AUGUSTINE, FL	6	1	16.7	10.2
SEBRING, FL	6	1	16.7	10.7
EFFINGHAM, SC	2	1	50.0	10.4
LIVE OAK, FL	2	1	50.0	13.0
NAPLES, FL	2	1	50.0	12.6
NEW MARKET, AL	2	1	50.0	10.8

GeoAccess®

ZIP Code detail information

All Employees

City	ZIP Code	Total number of employees	Total number of providers	All employees		
				Pct w	Pct wo	Average distance to a choice of 1 provider
ADDISON, AL	35540	1	0	0.0	100.0	15.6
AUBURN, AL	36830	1	8	100.0	0.0	0.0
DECATUR, AL	35601	1	1	100.0	0.0	1.8
HUNTSVILLE, AL	35811	1	0	100.0	0.0	1.6
JASPER, AL	35503	1	0	100.0	0.0	6.8
NEW MARKET, AL	35761	2	0	50.0	50.0	9.8
OZARK, AL	36360	1	1	100.0	0.0	6.3
TALLASSEE, AL	36078	1	0	0.0	100.0	18.1
BUCKEYE, AZ	85396	1	0	100.0	0.0	8.4
GLENDALE, AZ	85308	1	65	100.0	0.0	1.3
LITCHFIELD PARK, AZ	85340	1	0	100.0	0.0	1.3
SURPRISE, AZ	85379	1	3	100.0	0.0	1.1
SANTA BARBARA, CA	93101	1	0	100.0	0.0	3.2
VENTURA, CA	93001	1	0	100.0	0.0	1.7
BOULDER, CO	80304	1	0	100.0	0.0	1.4
CASTLE ROCK, CO	80109	1	1	100.0	0.0	2.0
COLORADO SPRINGS, CO	80927	1	0	100.0	0.0	2.4
DENVER, CO	80231	1	1	100.0	0.0	0.5
FAIRPLAY, CO	80440	1	0	0.0	100.0	41.4
LITTLETON, CO	80126	1	2	100.0	0.0	1.7
PEYTON, CO	80831	1	5	100.0	0.0	2.5
PUEBLO, CO	81007	1	0	100.0	0.0	3.9
SMYRNA, DE	19977	1	24	100.0	0.0	0.6
ALACHUA, FL	32615	1	1	100.0	0.0	7.6
APOPKA, FL	32712	1	0	100.0	0.0	4.1
AUBURNDALE, FL	33823	1	1	100.0	0.0	3.6
BASCOM, FL	32423	2	0	0.0	100.0	27.0
BELLEVIEW, FL	34420	2	1	100.0	0.0	1.2
BOCA RATON, FL	33428	8	4	100.0	0.0	1.3
	33431	1	3	100.0	0.0	0.8
	33432	2	5	100.0	0.0	0.6
	33433	7	3	100.0	0.0	0.9
	33486	4	0	100.0	0.0	1.3
	33487	1	3	100.0	0.0	0.9
	33498	1	1	100.0	0.0	0.0
BOKEELIA, FL	33922	1	0	100.0	0.0	8.2
BONIFAY, FL	32425	1	1	100.0	0.0	8.0
BOYNTON BEACH, FL	33426	2	4	100.0	0.0	0.8
	33436	1	10	100.0	0.0	1.1

Provider group: All Vision Providers

Access standard:

1 in 10

GeoAccess®

ZIP Code detail information

All Employees

City	ZIP Code	Total number of employees	Total number of providers	All employees		
				Pct w	Pct wo	Average distance to a choice of 1 provider
BOYNTON BEACH, FL	33437	5	1	100.0	0.0	1.2
	33472	2	0	100.0	0.0	1.7
	33473	2	0	100.0	0.0	2.0
BRANFORD, FL	32008	1	0	0.0	100.0	22.2
BRONSON, FL	32621	1	0	100.0	0.0	9.5
BROOKSVILLE, FL	34601	2	3	100.0	0.0	0.3
CANTONMENT, FL	32533	1	0	100.0	0.0	1.5
CAPE CANAVERAL, FL	32920	1	0	100.0	0.0	5.7
CAPE CORAL, FL	33904	1	18	100.0	0.0	1.0
	33909	1	1	100.0	0.0	2.0
CLERMONT, FL	34711	6	38	100.0	0.0	1.7
	34715	1	0	100.0	0.0	6.8
CLEWISTON, FL	33440	1	1	100.0	0.0	0.9
COCOA, FL	32926	1	1	100.0	0.0	1.0
CRAWFORDVILLE, FL	32327	1	11	100.0	0.0	5.2
DADE CITY, FL	33525	2	3	100.0	0.0	1.0
DANIA, FL	33004	32	4	100.0	0.0	0.6
DAYTONA BEACH, FL	32118	1	0	100.0	0.0	1.2
DE LEON SPRINGS, FL	32130	2	0	100.0	0.0	4.3
DEERFIELD BEACH, FL	33441	4	4	100.0	0.0	0.7
	33442	6	4	100.0	0.0	1.0
DELAND, FL	32720	3	4	100.0	0.0	3.9
	32724	4	0	100.0	0.0	2.5
DELRAY BEACH, FL	33444	2	2	100.0	0.0	1.2
	33445	1	1	100.0	0.0	0.4
	33446	4	2	100.0	0.0	0.9
	33484	2	1	100.0	0.0	0.9
DELTONA, FL	32725	1	0	100.0	0.0	2.7
DUNNELLON, FL	34430	1	0	100.0	0.0	0.7
	34431	1	0	100.0	0.0	7.8
	34432	2	1	100.0	0.0	5.0
	34433	1	0	100.0	0.0	7.3
EDGEWATER, FL	32141	3	1	100.0	0.0	1.7
FORT LAUDERDALE, FL	33301	6	0	100.0	0.0	0.8
	33302	1	0	100.0	0.0	1.0
	33303	1	0	100.0	0.0	0.9
	33304	3	1	100.0	0.0	0.9
	33305	4	3	100.0	0.0	0.3
	33306	2	5	100.0	0.0	0.1

GeoAccess®

Provider group: All Vision Providers

Access standard:

1 in 10

ZIP Code detail information

All Employees

City	ZIP Code	Total number of employees	Total number of providers	All employees		
				Pct w	Pct wo	Average distance to a choice of 1 provider
FORT LAUDERDALE, FL	33307	1	0	100.0	0.0	0.4
	33308	4	9	100.0	0.0	0.3
	33309	9	4	100.0	0.0	0.8
	33310	1	0	100.0	0.0	1.8
	33311	26	2	100.0	0.0	1.5
	33312	40	1	100.0	0.0	1.8
	33313	27	5	100.0	0.0	0.5
	33314	40	1	100.0	0.0	1.2
	33315	6	0	100.0	0.0	2.3
	33316	6	0	100.0	0.0	1.7
	33317	29	5	100.0	0.0	0.7
	33319	12	1	100.0	0.0	0.6
	33320	1	0	100.0	0.0	0.4
	33321	22	12	100.0	0.0	1.2
	33322	24	3	100.0	0.0	0.5
	33323	21	5	100.0	0.0	0.5
	33324	35	22	100.0	0.0	0.5
	33325	29	1	100.0	0.0	1.0
	33326	14	8	100.0	0.0	1.2
	33327	3	0	100.0	0.0	2.1
	33328	72	6	100.0	0.0	0.7
	33329	1	0	100.0	0.0	0.8
	33330	34	1	100.0	0.0	1.2
	33331	35	5	100.0	0.0	0.8
	33332	11	0	100.0	0.0	1.3
	33334	14	9	100.0	0.0	0.5
	33335	1	0	100.0	0.0	0.4
	33339	1	0	100.0	0.0	0.1
	33351	12	11	100.0	0.0	0.5
	33355	2	0	100.0	0.0	1.6
	33359	1	0	100.0	0.0	0.5
FORT MYERS, FL	33905	1	1	100.0	0.0	4.3
	33908	1	1	100.0	0.0	2.7
FORT PIERCE, FL	34949	1	0	100.0	0.0	5.1
	34950	1	3	100.0	0.0	1.5
	34951	2	0	100.0	0.0	3.9
FROSTPROOF, FL	33843	1	0	0.0	100.0	10.5
GAINESVILLE, FL	32653	2	1	100.0	0.0	1.6
GROVELAND, FL	34736	2	0	100.0	0.0	7.8

Provider group: All Vision Providers

Access standard:

1 in 10

GeoAccess®

ZIP Code detail information

All Employees

City	ZIP Code	Total number of employees	Total number of providers	All employees		
				Pct w	Pct wo	Average distance to a choice of 1 provider
HALLANDALE, FL	33008	2	0	100.0	0.0	0.8
	33009	30	3	100.0	0.0	0.6
HERNANDO, FL	34442	2	20	100.0	0.0	4.1
HIALEAH, FL	33010	1	7	100.0	0.0	0.1
	33012	4	38	100.0	0.0	0.4
	33013	2	2	100.0	0.0	0.5
	33014	8	11	100.0	0.0	0.7
	33015	6	3	100.0	0.0	0.6
	33016	3	7	100.0	0.0	0.3
	33018	3	8	100.0	0.0	0.7
HOBE SOUND, FL	33455	1	0	100.0	0.0	6.0
HOLLYWOOD, FL	33019	44	3	100.0	0.0	1.5
	33020	177	1	100.0	0.0	0.9
	33021	254	15	100.0	0.0	0.5
	33022	10	0	100.0	0.0	1.2
	33023	103	2	100.0	0.0	0.8
	33024	164	9	100.0	0.0	0.7
	33025	43	11	100.0	0.0	0.5
	33026	52	17	100.0	0.0	0.4
	33027	24	14	100.0	0.0	0.7
	33029	40	11	100.0	0.0	1.0
	33081	7	0	100.0	0.0	0.9
	33083	2	0	100.0	0.0	0.7
	33084	3	0	100.0	0.0	0.6
HOMESTEAD, FL	33035	1	0	100.0	0.0	0.8
HOMOSASSA, FL	34446	1	0	100.0	0.0	5.8
	34448	1	11	100.0	0.0	3.3
INTERLACHEN, FL	32148	1	0	0.0	100.0	10.6
INVERNESS, FL	34453	1	3	100.0	0.0	3.0
ISLAMORADA, FL	33036	1	0	0.0	100.0	16.2
JASPER, FL	32052	1	0	0.0	100.0	13.7
JENSEN BEACH, FL	34957	2	4	100.0	0.0	0.1
JUPITER, FL	33458	5	8	100.0	0.0	0.8
	33468	1	0	100.0	0.0	0.7
	33477	1	1	100.0	0.0	0.2
	33478	10	0	100.0	0.0	5.4
KEY LARGO, FL	33037	2	1	100.0	0.0	5.0
KISSIMMEE, FL	34743	1	0	100.0	0.0	1.9
	34758	1	0	100.0	0.0	4.3

Provider group: All Vision Providers

Access standard:

1 in 10

GeoAccess®

ZIP Code detail information

All Employees

City	ZIP Code	Total number of employees	Total number of providers	All employees		
				Pct w	Pct wo	Average distance to a choice of 1 provider
KISSIMMEE, FL	34759	2	21	100.0	0.0	2.7
LABELLE, FL	33935	1	0	0.0	100.0	16.5
LADY LAKE, FL	32159	4	17	100.0	0.0	2.1
LAKE CITY, FL	32024	1	0	100.0	0.0	2.3
LAKE PLACID, FL	33852	8	1	100.0	0.0	4.4
LAKE WALES, FL	33898	2	1	100.0	0.0	3.7
LAKE WORTH, FL	33449	1	0	100.0	0.0	2.4
	33462	2	6	100.0	0.0	0.7
	33463	3	5	100.0	0.0	0.6
	33467	6	1	100.0	0.0	1.9
LAKELAND, FL	33811	1	0	100.0	0.0	4.7
LAND O LAKES, FL	34638	1	0	100.0	0.0	7.0
LECANTO, FL	34461	1	0	100.0	0.0	7.0
LEESBURG, FL	34748	1	2	100.0	0.0	8.5
	34788	1	11	100.0	0.0	2.2
LEHIGH ACRES, FL	33936	1	0	100.0	0.0	1.6
	33971	1	4	100.0	0.0	1.1
LIVE OAK, FL	32060	2	1	50.0	50.0	8.9
LONGWOOD, FL	32779	1	0	100.0	0.0	2.3
LORIDA, FL	33857	1	0	0.0	100.0	14.4
LOXAHATCHEE, FL	33470	18	0	94.4	5.6	7.0
LYNN HAVEN, FL	32444	1	1	100.0	0.0	0.6
MACCLENNY, FL	32063	1	1	100.0	0.0	1.3
MADISON, FL	32340	1	0	0.0	100.0	25.3
MARATHON, FL	33050	1	0	0.0	100.0	52.0
MARCO ISLAND, FL	34145	1	0	100.0	0.0	9.8
MARIANNA, FL	32446	1	0	0.0	100.0	15.5
MELBOURNE, FL	32940	3	28	100.0	0.0	1.6
MELROSE, FL	32666	1	0	0.0	100.0	16.6
MERRITT ISLAND, FL	32952	1	1	100.0	0.0	1.1
MIAMI, FL	33125	2	0	100.0	0.0	0.8
	33127	2	3	100.0	0.0	0.7
	33129	3	1	100.0	0.0	0.4
	33130	2	0	100.0	0.0	0.7
	33131	1	1	100.0	0.0	0.8
	33132	1	0	100.0	0.0	0.9
	33133	1	0	100.0	0.0	0.4
	33134	1	14	100.0	0.0	0.0
	33138	1	1	100.0	0.0	0.3

GeoAccess®

Provider group: All Vision Providers

Access standard:

1 in 10

ZIP Code detail information

All Employees

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				Pct w	Pct wo	Average distance to a choice of 1 provider
MIAMI, FL	33144	1	13	100.0	0.0	0.1
	33145	2	16	100.0	0.0	0.3
	33147	4	3	100.0	0.0	0.9
	33150	3	0	100.0	0.0	0.9
	33155	3	16	100.0	0.0	0.6
	33156	1	23	100.0	0.0	0.0
	33157	4	5	100.0	0.0	0.7
	33161	6	1	100.0	0.0	1.1
	33162	7	10	100.0	0.0	1.0
	33165	5	4	100.0	0.0	0.6
	33166	3	5	100.0	0.0	0.5
	33167	1	0	100.0	0.0	1.9
	33168	7	0	100.0	0.0	1.3
	33169	12	2	100.0	0.0	1.5
	33170	1	0	100.0	0.0	1.6
	33173	1	9	100.0	0.0	0.3
	33174	1	5	100.0	0.0	0.3
	33175	2	12	100.0	0.0	0.3
	33176	2	35	100.0	0.0	0.1
	33177	3	3	100.0	0.0	1.0
	33179	13	16	100.0	0.0	0.4
	33180	4	12	100.0	0.0	0.4
	33182	1	0	100.0	0.0	1.7
	33185	1	0	100.0	0.0	1.9
	33186	3	17	100.0	0.0	0.7
	33187	1	0	100.0	0.0	0.9
	33193	3	0	100.0	0.0	1.2
	33196	1	6	100.0	0.0	5.1
	33269	1	0	100.0	0.0	1.2
	33280	1	0	100.0	0.0	0.3
MIAMI BEACH, FL	33139	2	5	100.0	0.0	0.4
	33141	1	3	100.0	0.0	0.3
	33154	1	1	100.0	0.0	0.4
MIAMI GARDENS, FL	33056	9	1	100.0	0.0	1.2
MILTON, FL	32570	2	4	100.0	0.0	1.3
MONTICELLO, FL	32344	3	7	100.0	0.0	2.9
MOORE HAVEN, FL	33471	1	0	0.0	100.0	10.7
MORRISTON, FL	32668	1	0	100.0	0.0	8.4
MOUNT DORA, FL	32757	1	1	100.0	0.0	1.5

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NAPLES, FL	34114	1	2	100.0	0.0	2.7
	34120	1	0	0.0	100.0	12.6
NAVARRE, FL	32566	1	1	100.0	0.0	0.6
NEW SMYRNA BEACH, FL	32168	2	0	100.0	0.0	5.5
NORTH FORT MYERS, FL	33917	1	0	100.0	0.0	7.5
NORTH MIAMI BEACH, FL	33160	2	3	100.0	0.0	0.7
NORTH PALM BEACH, FL	33408	1	1	100.0	0.0	0.8
NORTH PORT, FL	34288	2	0	100.0	0.0	1.9
O BRIEN, FL	32071	1	0	0.0	100.0	15.8
OCALA, FL	34471	1	19	100.0	0.0	1.6
	34472	1	1	100.0	0.0	2.9
	34476	3	0	100.0	0.0	3.0
	34480	2	0	100.0	0.0	3.5
	34481	1	22	100.0	0.0	6.1
	34482	2	0	100.0	0.0	7.7
OCKLAWAHA, FL	32179	1	0	100.0	0.0	9.5
OCOEE, FL	34761	1	32	100.0	0.0	0.3
OKEECHOBEE, FL	34972	1	1	100.0	0.0	2.1
	34974	1	5	100.0	0.0	7.6
OPA LOCKA, FL	33054	3	0	100.0	0.0	1.2
	33055	10	2	100.0	0.0	0.6
ORANGE PARK, FL	32065	1	14	100.0	0.0	1.0
	32073	1	29	100.0	0.0	1.1
ORLANDO, FL	32810	1	0	100.0	0.0	1.9
ORMOND BEACH, FL	32174	5	4	100.0	0.0	2.9
	32176	1	0	100.0	0.0	5.0
PALM BAY, FL	32905	1	2	100.0	0.0	2.5
	32908	1	0	100.0	0.0	2.4
	32909	1	0	100.0	0.0	7.1
PALM BEACH GARDENS, FL	33410	1	7	100.0	0.0	2.0
	33418	2	1	100.0	0.0	1.9
PALM CITY, FL	34990	3	1	100.0	0.0	2.3
PALM COAST, FL	32137	5	0	100.0	0.0	2.5
	32164	4	1	100.0	0.0	2.9
PALM HARBOR, FL	34684	1	45	100.0	0.0	0.9
PEMBROKE PINES, FL	33028	30	4	100.0	0.0	0.8
PLANT CITY, FL	33566	1	1	100.0	0.0	3.4
POMPANO BEACH, FL	33060	6	1	100.0	0.0	1.1
	33062	8	6	100.0	0.0	0.6

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POMPANO BEACH, FL	33063	13	15	100.0	0.0	0.5
	33064	7	8	100.0	0.0	0.7
	33065	11	6	100.0	0.0	0.4
	33066	5	0	100.0	0.0	1.5
	33067	7	8	100.0	0.0	0.9
	33068	4	2	100.0	0.0	0.7
	33069	1	7	100.0	0.0	0.6
	33071	15	3	100.0	0.0	1.4
	33073	11	4	100.0	0.0	0.9
	33076	12	3	100.0	0.0	0.9
PONCE DE LEON, FL	32455	1	0	0.0	100.0	12.2
PORT CHARLOTTE, FL	33981	2	0	100.0	0.0	3.9
PORT SAINT LUCIE, FL	34952	4	5	100.0	0.0	1.4
	34953	10	3	100.0	0.0	2.2
	34983	3	0	100.0	0.0	1.5
	34986	4	4	100.0	0.0	2.2
	34987	2	3	100.0	0.0	4.0
PUNTA GORDA, FL	33982	2	0	100.0	0.0	6.9
ROCKLEDGE, FL	32955	1	2	100.0	0.0	1.1
SAINT AUGUSTINE, FL	32080	1	0	100.0	0.0	2.9
	32084	1	0	100.0	0.0	5.2
	32086	1	20	100.0	0.0	1.9
	32092	3	3	66.7	33.3	7.5
SAINT CLOUD, FL	34770	1	0	100.0	0.0	0.2
SAN ANTONIO, FL	33576	1	0	100.0	0.0	5.1
SANFORD, FL	32771	1	30	100.0	0.0	0.7
SANIBEL, FL	33957	1	0	0.0	100.0	13.6
SARASOTA, FL	34235	1	0	100.0	0.0	1.5
	34236	1	4	100.0	0.0	0.8
SEBASTIAN, FL	32958	6	5	100.0	0.0	2.1
	32976	1	0	100.0	0.0	3.2
SEBRING, FL	33870	1	28	100.0	0.0	3.6
	33875	2	0	100.0	0.0	2.5
	33876	3	0	66.7	33.3	9.4
SILVER SPRINGS, FL	34488	2	1	100.0	0.0	4.0
SORRENTO, FL	32776	1	0	100.0	0.0	7.9
SPRING HILL, FL	34609	1	3	100.0	0.0	2.0
STUART, FL	34994	2	4	100.0	0.0	0.3
	34997	3	3	100.0	0.0	1.5

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GeoAccess®

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TALLAHASSEE, FL	32308	1	4	100.0	0.0	0.4
TAMPA, FL	33646	1	0	100.0	0.0	0.4
TARPON SPRINGS, FL	34688	1	0	100.0	0.0	2.8
TAVARES, FL	32778	2	0	100.0	0.0	3.4
TAVERNIER, FL	33070	3	0	0.0	100.0	12.5
THE VILLAGES, FL	32162	4	21	100.0	0.0	1.3
	32163	1	0	100.0	0.0	0.3
TRENTON, FL	32693	1	0	0.0	100.0	14.7
UMATILLA, FL	32784	2	1	100.0	0.0	3.6
VERO BEACH, FL	32960	2	2	100.0	0.0	1.0
	32962	1	1	100.0	0.0	0.7
	32963	1	0	100.0	0.0	3.4
	32966	3	2	100.0	0.0	1.8
	32967	3	0	100.0	0.0	2.6
WALDO, FL	32694	1	0	0.0	100.0	10.3
WELLINGTON, FL	33414	6	10	100.0	0.0	0.8
WEST PALM BEACH, FL	33404	1	0	100.0	0.0	1.9
	33411	7	5	100.0	0.0	1.7
	33412	6	0	100.0	0.0	6.5
	33413	1	0	100.0	0.0	2.0
WIMAUMA, FL	33598	1	1	100.0	0.0	2.4
WINTER GARDEN, FL	34787	1	7	100.0	0.0	0.6
WINTER HAVEN, FL	33881	2	21	100.0	0.0	1.5
	33884	2	1	100.0	0.0	1.5
WINTER SPRINGS, FL	32708	1	22	100.0	0.0	1.8
ALPHARETTA, GA	30022	1	16	100.0	0.0	0.7
BLAIRSVILLE, GA	30512	3	1	100.0	0.0	5.9
BUFORD, GA	30518	1	0	100.0	0.0	3.9
COLUMBUS, GA	31917	1	0	100.0	0.0	1.7
CUMMING, GA	30028	1	0	100.0	0.0	2.1
	30040	3	5	100.0	0.0	1.6
EASTMAN, GA	31023	1	3	100.0	0.0	6.7
FAIRMOUNT, GA	30139	1	0	100.0	0.0	3.1
FAYETTEVILLE, GA	30215	1	0	100.0	0.0	4.2
HIAWASSEE, GA	30546	1	0	0.0	100.0	17.1
JESUP, GA	31545	1	3	100.0	0.0	1.7
MARIETTA, GA	30062	1	34	100.0	0.0	0.9
POWDER SPRINGS, GA	30127	1	0	100.0	0.0	1.8
ROSWELL, GA	30076	1	8	100.0	0.0	1.6

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SENOIA, GA	30276	1	0	100.0	0.0	5.8
SOPERTON, GA	30457	1	0	0.0	100.0	16.2
TOWNSEND, GA	31331	1	0	0.0	100.0	20.9
WASHINGTON, GA	30673	1	0	0.0	100.0	26.0
WOODSTOCK, GA	30188	2	17	100.0	0.0	1.2
JEFFERSONVILLE, IN	47130	1	12	100.0	0.0	0.7
CYNTHIANA, KY	41031	1	1	100.0	0.0	0.6
EDMONTON, KY	42129	1	2	100.0	0.0	2.9
ELIZABETHTOWN, KY	42701	1	45	100.0	0.0	2.2
NEBO, KY	42441	1	0	0.0	100.0	10.6
BOSSIER CITY, LA	71111	1	11	100.0	0.0	1.1
TRURO, MA	02666	1	0	0.0	100.0	18.5
SALISBURY, MD	21804	1	6	100.0	0.0	1.3
CANTON, MI	48188	1	2	100.0	0.0	1.5
COLUMBIA, MO	65201	1	20	100.0	0.0	0.2
GULFPORT, MS	39503	1	4	100.0	0.0	4.0
ANDREWS, NC	28901	1	0	0.0	100.0	10.3
APEX, NC	27539	1	0	100.0	0.0	1.7
ASHEVILLE, NC	28801	1	0	100.0	0.0	1.1
	28816	1	0	100.0	0.0	1.2
BANNER ELK, NC	28604	1	0	0.0	100.0	12.6
CANTON, NC	28716	1	0	0.0	100.0	10.6
CONCORD, NC	28025	2	11	100.0	0.0	1.1
CULLOWHEE, NC	28723	1	0	0.0	100.0	11.8
FRANKLIN, NC	28734	3	4	100.0	0.0	4.4
FUQUAY VARINA, NC	27526	1	7	100.0	0.0	1.9
GERMANTON, NC	27019	1	0	100.0	0.0	6.1
HENDERSONVILLE, NC	28739	1	0	100.0	0.0	3.2
INDIAN TRAIL, NC	28079	1	1	100.0	0.0	4.6
KERNERSVILLE, NC	27284	1	4	100.0	0.0	1.7
MARION, NC	28752	1	15	100.0	0.0	2.0
MURPHY, NC	28906	1	2	0.0	100.0	10.8
OTTO, NC	28763	1	0	0.0	100.0	10.2
SALUDA, NC	28773	1	0	100.0	0.0	8.8
WAXHAW, NC	28173	1	0	100.0	0.0	6.2
WHITSETT, NC	27377	1	0	100.0	0.0	3.1
WILMINGTON, NC	28403	1	27	100.0	0.0	1.0
ZIONVILLE, NC	28698	1	0	100.0	0.0	9.3
EFFINGHAM, NH	03882	1	0	0.0	100.0	19.4

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LOS LUNAS, NM	87031	1	29	100.0	0.0	5.0
LAS VEGAS, NV	89110	1	21	100.0	0.0	1.0
	89134	1	0	100.0	0.0	1.3
FULTON, NY	13069	1	2	100.0	0.0	8.9
MONROE, NY	10950	1	3	100.0	0.0	3.1
OCEANSIDE, NY	11572	1	7	100.0	0.0	0.0
PITTSFORD, NY	14534	1	0	100.0	0.0	0.3
CLEVELAND, OH	44126	1	6	100.0	0.0	1.5
EAST LIVERPOOL, OH	43920	1	1	100.0	0.0	3.3
HAMILTON, OH	45011	1	3	100.0	0.0	1.0
TULSA, OK	74133	1	21	100.0	0.0	0.9
ASHLAND, OR	97520	1	1	100.0	0.0	0.7
CANONSBURG, PA	15317	1	8	100.0	0.0	0.6
DU BOIS, PA	15801	1	5	100.0	0.0	0.6
PITTSBURGH, PA	15225	1	0	100.0	0.0	2.6
WILKES BARRE, PA	18706	1	0	100.0	0.0	3.4
WILLIAMSTOWN, PA	17098	1	0	100.0	0.0	8.8
EASLEY, SC	29642	1	0	100.0	0.0	6.6
EFFINGHAM, SC	29541	2	0	50.0	50.0	9.1
GRANITEVILLE, SC	29829	1	0	100.0	0.0	4.6
ROCK HILL, SC	29732	1	2	100.0	0.0	3.8
SIMPSONVILLE, SC	29681	1	0	100.0	0.0	4.9
YORK, SC	29745	1	2	100.0	0.0	4.2
MADISON, SD	57042	1	0	0.0	100.0	24.5
AFTON, TN	37616	1	0	100.0	0.0	5.8
ATHENS, TN	37303	1	1	100.0	0.0	2.6
BELL BUCKLE, TN	37020	1	0	100.0	0.0	7.7
CLEVELAND, TN	37323	2	1	100.0	0.0	3.7
COOKEVILLE, TN	38506	2	0	100.0	0.0	3.1
CROSSVILLE, TN	38555	2	6	100.0	0.0	1.1
DUNLAP, TN	37327	7	0	0.0	100.0	14.7
GOODLETTSVILLE, TN	37072	1	43	100.0	0.0	3.8
KNOXVILLE, TN	37934	1	27	100.0	0.0	1.0
LOUDON, TN	37774	1	0	100.0	0.0	6.2
LOUISVILLE, TN	37777	1	0	100.0	0.0	4.2
LUTTS, TN	38471	1	0	0.0	100.0	17.9
MARYVILLE, TN	37804	1	0	100.0	0.0	0.6
MOUNTAIN CITY, TN	37683	1	3	100.0	0.0	3.0
ROGERSVILLE, TN	37857	1	1	100.0	0.0	1.6

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SAVANNAH, TN	38372	1	3	100.0	0.0	6.6
SEYMOUR, TN	37865	1	0	100.0	0.0	5.7
SODDY DAISY, TN	37379	1	5	100.0	0.0	9.8
BACLIFF, TX	77518	1	0	100.0	0.0	2.8
DENISON, TX	75020	1	4	100.0	0.0	2.4
HUNTSVILLE, TX	77340	1	1	100.0	0.0	0.9
KINGWOOD, TX	77345	1	0	100.0	0.0	1.8
PEARLAND, TX	77584	1	33	100.0	0.0	0.2
SAN ANTONIO, TX	78255	1	0	100.0	0.0	1.7
CHARLOTTESVILLE, VA	22901	1	4	100.0	0.0	1.6
DUMFRIES, VA	22026	1	2	100.0	0.0	0.4
FAIRFAX STATION, VA	22039	1	0	100.0	0.0	1.5
GALAX, VA	24333	1	1	100.0	0.0	8.1
PHILOMONT, VA	20131	1	0	100.0	0.0	4.9
VINTON, VA	24179	1	5	100.0	0.0	0.4
WINCHESTER, VA	22602	1	2	100.0	0.0	0.8
CHESTER, VT	05143	1	0	0.0	100.0	19.7
RUTLAND, VT	05701	1	1	100.0	0.0	1.5
CEDARBURG, WI	53012	1	1	100.0	0.0	0.8
CHIPPEWA FALLS, WI	54729	1	6	100.0	0.0	6.6
OAK CREEK, WI	53154	1	6	100.0	0.0	0.3
BRIDGEPORT, WV	26330	1	0	100.0	0.0	1.9
HUNTINGTON, WV	25701	2	0	100.0	0.0	3.6
WEIRTON, WV	26062	1	1	100.0	0.0	0.6
TOTALS		**2,390**	**1,947**	**97.7**	**2.3**	**1.6**

Provider group: All Vision Providers

Access standard:

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GeoAccess®

Vision Provider Counts in these counties in Florida:

- Broward = 290
- Miami-Dade = 432
- Palm Beach = 148

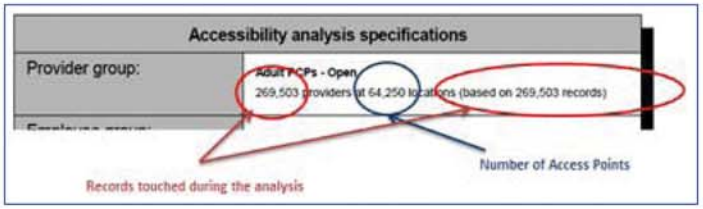
Understanding your UnitedHealthcare GeoAccess report

UnitedHealthcare knows that there are many different ways to represent provider strength and access in a GeoAccess Report. We understand the value that these results provide during carrier selection. Since the GeoNetwork software includes many different ways to portray results, we want to be clear with you, our customer, about the approach used to complete these reports. We hope that this information provides you with what you need to perform a complete evaluation of the value of our network.

GeoAccess report definitions:

The Accessibility Summary and Accessibility Overview pages in your GeoAccess report will include counts of providers, locations and records. While there are many different ways to do counts, this is what those numbers represent in our reports.

- **Providers** – the count of provider records we have on file at the time of the report. A provider record represents participating provider / location combinations. Providers with multiple locations would be counted multiple times.
- **Locations** – the count of unique longitude/latitude combinations in the data. Many providers may have offices in at the same location, but this does not necessarily mean the providers are affiliated with one another or part of the same practice.
- **Records** – the count of provider records we have on file at the time of the report. A provider record represents participating provider / location combinations. Providers with multiple locations would be counted multiple times.



example

Calculating provider proximity:

The GeoNetwork software offers two options for calculating provider distance:

- As-the-crow-flies distance: Measures member to provider location in a straight line.
- Estimated driving distance: Measures member to provider location using assumptions about the route taken and other variables.

Unless otherwise instructed, UnitedHealthcare runs GeoAccess Reports using the ***as-the-crow-flies calculation method***.

- Census files provided with member address, city, state and zip code allows our Network Analysts to plot members in the exact location of their home for purposes of measuring to providers.
- Census files provided with only member zip codes will require our Network Analysts to use a representative approach when plotting members to derive accessibility.

It is important to understand the specific definitions and calculations used in the network analysis process to help interpret the results.

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