EXHIBIT
A

TENNESSEE DEPARTMENT

OF

COMMERCE AND INSURANCE

MARKET CONDUCT EXAMINATION REPORT

OF

UNITED HEALTHCARE OF TENNESSEE, INC.

RECEIVED
AUG 0 4 2006
Dept. Of Commerce & Insurance
Company Examinations

AS OF

DECEMBER 31, 2004

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Brentwood, Tennessee
July 27, 2006

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

Dear Commissioner:

Pursuant to your instructions and in accordance with the State of Tennessee insurance laws and regulations and resolutions adopted by the National Association of Insurance Commissioners, a market conduction examination was made of

UNITED HEALTHCARE OF TENNESSEE, INC.
10 CADILLAC DRIVE, SUITE 200
BRENTWOOD, TN 37027

hereinafter and generally referred to as the Plan, and a report thereon is submitted as follows:

The Plan's records were examined at its principal executive office located at the above address.

PURPOSE AND SCOPE OF EXAMINATION

Under authorization of The Department of Commerce and Insurance, State of Tennessee (the Department) and in accordance with Tennessee insurance laws and regulations and resolutions adopted by the National Association of Insurance Commissioners (NAIC), a market conduct examination of United Healthcare of Tennessee, Inc. (the Plan) was performed by Ann M. McClain, CIE, FLMI, FLHC, CCP, AIRC, AIAA, ARA, AIS, ACS, William A. Dow, III, AIE, FLMI and Edward Chandler, independent market conduct examiners. The scope of this examination was January 1, 2002 through December 31, 2004. The examination began May 2, 2005. The last market conduct examination of the Plan by the Department was concluded December 31, 2000.

The purpose of this examination was to verify the Plan's compliance with Tennessee laws and regulations.

In reviewing materials for this report, the examiners relied primarily on records maintained by the Plan. The examination included, but was not limited to, a review of the Plan's operations/management, health maintenance organization (HMO) policies, claims, consumer complaints and complaint handling. The files examined were selected systematically from data files provided by the Plan using Microsoft Excel's "random sample" selection process. The examination report is a report by exception. As a result, files or material reviewed containing no improprieties by the Plan have been omitted from the examination report. Procedures and conduct of the examination were in accordance with the Market Conduct Examiner's Handbook produced by the NAIC.

Zero tolerance levels were applied to all improprieties by the Plan that were in violation of Tennessee laws and regulations.

The last market conduct examination of the Plan by the Department covered the period from January 1, 1997 through December 31, 2000 and was conducted in conjunction with the financial examination for the same time period. The recommendations regarding market conduct issues made in the preceding report and the corrective actions taken by the Plan are as follows:

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

Corrective Action: Testing of policy files to verify compliance with filed forms is detailed on page seven (7) of this report.

(2) "Minor discrepancies were noted in the Plan's application of the filed rating methodology for large groups, some of which were due to typographical errors in the rate filings. It is recommended that the Plan file and apply its rating methodologies in accordance with TCA 56-32-207(b)."

Corrective Action: Testing of policy files to verify compliance with filed forms is detailed on page seven (7) of this report.

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

Corrective Action: The Plan assisted in preparing a detail stratification of clams processed for calendar year, 2004 which is included on pages eleven (11) and twelve (12) of this report. Further discussion is included under the heading "REPORT SUMMARIZATION" on page thirteen (13) of this report.

OPERATIONS/MANAGEMENT

The Plan is a corporation maintaining its principal executive office in the state of Tennessee. "The Plan was incorporated in Tennessee on September 17, 1990, under the name of Complete Health of Tennessee, Inc., and was organized as a health maintenance corporation pursuant to Title 56, Chapter 32, Tennessee Code Annotated (Tenn. Code Ann. § 56-32) to provide health care services to residents of the State of Tennessee." The current Certificate of Authority dated January 26, 2001, is valid until canceled or revoked. The review included a verification of the lines of business the Plan was authorized to write versus the lines actually written.

The Plan was originally a wholly-owned subsidiary of Complete Health Services, Inc., an Alabama corporation. In May of 1994, Complete Health Services, Inc. was acquired by United HealthCare Corporation. The Plan was merged into Complete Health Services, Inc. at that time, and the sole surviving entity, Complete Health Services, Inc., became a wholly-owned subsidiary of the United HealthCare Corporation. In September of 1995, the Plan's name was changed to United HealthCare South, Inc. In April 1996, United Health Care South, Inc. was purchased by United HealthCare Services, Inc., another wholly-owned subsidiary of United HealthCare Corporation, and the name of the Plan was again changed in May of 1996 to United HealthCare of Tennessee, Inc. In April of 2000, United HealthCare Services, Inc. transferred its ownership interest in the Plan to another wholly-owned subsidiary, UnitedHealthcare, Inc. UnitedHealthcare, Inc. is a wholly-owned subsidiary of United HealthCare Services, Inc., which, in turn, is a wholly-owned subsidiary of UnitedHealth Group Incorporated.

The Plan's primary executive office is located at 10 Cadillac Drive, Suite 200, Brentwood, Tennessee. The Plan also has local service area offices for sales and marketing of existing and new employer groups and network management of participating physicians, hospitals and health care facilities. The local service offices are located at the following locations:

408 N. Cedar Bluff Road, #300
Knoxville, TN 37923

633 Chestnut Street, Suite 1010
Chattanooga, TN 37450

871 Ridgeway Loop Road, Suite 212
Memphis, TN 38120

As of July 15, 2005, the date that initial claim testing was complete, the following persons were serving as the Plan's primary corporate officers:

C. Brian Shipp	President and Chief Executive Officer
David S. Wichmann	Vice President and Assistant Treasurer
Michael J. McDonnell	Secretary
Robert W. Oberrender	Treasurer

PLAN PROCESSES/STATISTICAL AFFILIATIONS

Computer System

The Plan utilizes IBM mainframe computers to run the OS/390 operating system. The Plan utilizes two primary systems for policy and claims administration: the Comprehensive On-line System for Management and Operational Support (COSMOS) and United Healthcare Network of Systems (UNET). COSMOS is maintained by Unisys Technical Support and by Unix Services & Consulting. The Plan utilizes the Unisys Data Center located in Eagan, Minnesota, for major processing in connection with COSMOS. Processing of the Plan's UNET system occurs at the IBM Global Services facility located in Southbury, Connecticut. In addition, the Plan utilizes several Local Area Networks (LAN). A Wide Area Network (WAN) used primarily for connectivity within the organizational realm is administered by a facility located in Plymouth, Minnesota.

The Plan's computer equipment is located in secure areas, and the Data Center is equipped with fire detection, suppression systems and a water detection system. The Data Center also has several uninterruptible power supplies and available diesel-powered generators for additional backup.

Anti-Fraud Plan

The Plan is a wholly-owned subsidiary of UnitedHealthcare, Inc., which in turn is a wholly-owned subsidiary of United HealthCare Services, Inc. The anti-fraud plan of United HealthCare Services, Inc. is adopted and implemented by all of the health plans it owns directly or indirectly. United HealthCare Services, Inc. has an established Special Investigations Unit consisting of approximately forty-eight (48) investigators and is operated by Ingenix. Ingenix is the health care information and research segment of United HealthCare Services, Inc. and provides compliance research and monitoring, detection technology, investigation and recovery services (financial loss resulting from insurance fraud), training, consulting and subrogation.

The Plan and Ingenix receive fraud or suspicious claim referrals through the following: members, providers, other insurers, the general public, claims personnel, medical management, claims review staff, quality assurance staff, review personnel and provider credentialing units; Ingenix's relationship with the National Health Care Anti-Fraud Association; studies conducted by The Plan or Ingenix; and, law enforcement agencies.

Disaster Recovery Plan

The Plan has developed a Disaster Recovery Plan providing specific instructions to be followed during an incident or disaster situation, which are designed to minimize the impact of interrupted services and allow recovery to full business resumption. The Disaster Recovery Plan focuses on recovery of critical applications at alternate facilities. The alternate site for the IBM Data Center

(UNET) is located in Gathersburg, MD, and the alternate site for the Unisys Data Center (COSMOS) is located in Salt Lake City, UT. Both facilities are tested at least once annually.

Internal Audit Procedures

The Plan has developed internal audit procedures and utilizes an independent accounting firm, Deloitte and Touche, LLP, to review its statutory financial statements annually. The independent accounting firm prepares an annual audit report, which includes recommendations for improvement in the internal control structure of the Plan, if needed.

In addition, personnel are trained to report any suspected internal fraud or abuse to their supervisor who, in turn, will forward a report to the Special Investigations Unit which is discussed under the caption, "Anti-Fraud Plan. Following such a report, the Special Investigations Unit investigates the allegations, and together with Legal Services determines whether or not the results of the investigation must be reported to a government entity or other third party.

Privacy Plan

The Plan sends annual privacy notices to all insured subscribers outlining their privacy and confidentiality rights. The Plan has instituted training procedures for its employees and developed an internal audit tool to verify compliance. The Plan provides its agents and brokers with information bulletins in connection with privacy rights and has contracted with its vendors to handle on-site shredding of confidential material. The Plan is deemed in compliance with Tenn. Comp. R. & Regs. Tit. Dep't of Commerce and Ins., ch. 0780-1-72

Statistical Affiliations

The Plan acts as its own statistical agent.

OPERATIONS/MARKETING

Management and Control

The Plan has no employees of its own. Personnel and services are provided by the Plan's affiliate, United HealthCare Services, Inc. in accordance with a management agreement, which requires annual completion of conflicts of interest and outside directorships on a disclosure form, and provided for review to UnitedHealth Group Incorporated legal services. In addition, the Plan's secretary submits an annual Conflict of Interest Report to the Board of Directors.

Personnel are not allowed to serve on the board of directors of any company competing with UnitedHealth Group or having a significant commercial relationship with UnitedHealth Group. In addition, the Plan has an integrity officer assigned by United HealthGroup to administer its comprehensive Integrity and Compliance Program.

Marketing

The Plan is licensed by the State of Tennessee to provide health care services to the residents of Tennessee. The Plan transacts the business of health care services, as defined in Tenn. Code Ann. § 56-32. The Plan services all counties in the State of Tennessee except for the following: Carter, Clay, Fentress, Grainger, Henry, Johnson, Morgan, Pickett, Statewide, Sullivan, Unicoi, Union, Washington and Weakley. The Plan is not currently licensed in these counties primarily due to low population.

The Plan appoints independent brokers as authorized agents under a standard brokerage agreement to market its products.

The Plan contracts with physicians, hospitals, pharmacies and other medical providers to provide health care services to its members. The contracts comply with Tenn. Code Ann. § 56-32-205(c) and relieve "any liability for services rendered by such providers except for reasonable co-payment and uncovered expenses." In addition, the contracts contain a "Member Protection Provision" complying with Tenn. Code Ann. § 56-32-205(c).

Advertising

The Plan advertises to both the general consumer population as well as to prospective customer companies. Advertising directed at the general population utilizes magazine ads, television ads and radio ads. In its advertising to prospective customer companies, the Plan publishes ads in human resource trade magazines and business journal weeklies nationwide. The Plan develops all its advertising material and prohibits any unauthorized advertising. Agencies are not allowed to advertise independently.

REVIEW OF POLICIES

HEALTH MAINTENANCE ORGANIZATION

The current examination encompassed a complete review of the Plan's two HMO products, "Choice" and "Select", in addition to its "ChoicePlus" benefit plan. The Choice and Select plans provide benefits to members who pay varying co-payments for services obtained from the Plan's provider network. The ChoicePlus product provides members a non-HMO product in conjunction with an HMO product. Under ChoicePlus, members can choose a pure HMO and pay stated co-payments for services obtained through the Plan's provider network or use providers outside the Plan's provider network and pay a deductible and a percentage of covered expenses.

Premium and Policy Counts

Total premiums paid (TPP) and in-force policy counts for the scope of the examination are as follows:

Year	TPP	In-Force Policy Count
2002	$165,069,023	2,746
2003	$136,450,675	2,213
2004	$80,329,231	1,229

The decrease in both the premium and in-force policy counts is a direct result of the decrease in overall market demand for HMO products. The Plan is increasing its health insurance business as its HMO products decrease.

POLICY REVIEW

Sample Review Findings

One hundred (100) policy files were examined as follows:

1. Fifty (50) policy files were reviewed to verify compliance with filed forms, underwriting guidelines, and rates.

   No errors were found.

2. Fifty (50) policy files were reviewed to verify that proper cancellation procedures were followed.

   No errors were found.

COMPLAINT SYSTEM

The Plan has established complaint procedures that comply with Tenn. Code Ann. § 56-3-210.

Complaints Received From Plan Members - Sample Review Findings

One hundred (100) complaint files received directly from Plan members were examined.

Twenty-two (22) complaint files contained a total of thirty (30) errors.

The errors are as follows:

1. Nine (9) errors were due to failure by the Plan to advise the member, upon receipt of the complaint, of his or her right to submit written material and obtain the assistance of any uninvolved member of the staff. These errors constitute a violation of Tenn. Code Ann. § 56-32-210(c)(6).

Sample Size	Number of Files in Error	Percentage to Sample
100	9	9%

The Plan has been advised of these errors.

The Plan agreed with these findings and has implemented procedures to properly advise members upon receipt of a complaint or appeal of the members' rights pursuant to Tenn. Code Ann. § 56-32-210(c)(6).

2. Twenty-one (21) errors were due to failure by the Plan to review complaints within ten (10) working days of receipt of the complaint, and to issue the covered person a written decision regarding a denied claim within five (5) working days from the date of the review. These errors constitute a violation of Tenn. Code Ann. §§ 56-32-210(c)(5) and 210(c)(7).

Sample Size	Number of Files in Errors	Percentage to Sample
100	13	13%

The Plan has been advised of these errors.

The Plan agreed with these findings, and in June 2005 implemented a system enhancement database to provide better tracking of appeals and complaints handled by its National Appeals Service Center (NASC). The enhancement was made to ensure that determination letters are sent to its members on a timely basis.

Complaints Received By The Tennessee Department of Commerce and Insurance – Sample Review Findings

Twenty-five (25) complaints received by The Tennessee Department of Commerce and Insurance, Division of Consumer Insurance Services were examined.

No errors were found.

During the examination, nine (9) of the twenty-five (25) files reviewed were found to be missing all or part of the written correspondence pertaining to the complaint. The Plan has agreed that documentation was missing from these nine (9) files and has established standards through its NASC department for maintaining proper document retention and case file content with regards to member appeals and complaints.

In addition, as of the date, July 15, 2005 when initial claim sampling was complete, there were five (5) claims reported to the Division of Consumer Insurance Services for which the Plan has made no response. These claims are over thirty (30) days old. These errors constitute a violation of Tenn. Code Ann. §§ 56-32-210(c)(5) and 210(c)(7).

CLAIMS REVIEW

DESCRIPTION OF CLAIMS REVIEWED

This examination included the review of provider and prescription claims made by the Plan's members under its health insurance products.

Sample Review Findings

One hundred (100) files were reviewed. The claim files reviewed were selected systematically from this list using Microsoft Excel's "sampling" selection process.

Seven (7) errors were found related to the prompt payment of claims.

Prompt Payment of Claims

The errors related to the prompt payment of claims are as follows:

> Seven (7) errors were due to failure by the Plan to pay or respond to electronic claims within twenty-one (21) days of receipt. These errors constitute a violation of Tenn. Code Ann. § 56-7-109.

Sample Size	Number of Files in Error	Percentage to Sample
100	7	7%

> The Plan has been advised of these errors.
>
> The Plan agreed with these findings and has implemented procedures to ensure payment of or response to electronic claims within twenty-one (21) days of receipt.

At the Department's request, the Plan stratified the entire claim population for the year, 2004, into clean claims by month in order to measure timeliness of payment. Tenn. Code Ann. § 56-7-109 requires payment within twenty-one (21) days for electronic clean claims and thirty (30) days for paper clean claims. The results of this stratification are as follows:

Electronic medical claims = EDI	21 day requirement
Pharmacy claims (all are electronic)	21 day requirement
Paper medical claims (medical only)	30 day requirement

	Jan	Feb	Mar	Apr
% EDI Med Claims Paid within 21 Cal. Days	96.5%	97.7%	98.6%	98.1%
Total EDI Medical Claims Paid within 21 Cal. Days	28,522	25,862	24,627	23,353
Total EDI Medical Claims Processed	29,545	26,484	24,979	23,808
% of Paper Medical Claims Paid within 30 Cal. Days	96.0%	96.2%	98.1%	97.9%
Total Paper Medical Claims Paid within 30 Cal. Days	9,945	9,225	9,030	7,707
Total Paper Medical Claims Processed	10,364	9,592	9,208	7,876
% of Pharmacy Claims paid within 21 Cal. Days	59.9%	59.3%	58.0%	57.7%
Total Pharmacy Claims paid within 21 Cal. Days	22,113	12,916	12,136	10,982
Total Pharmacy Claims processed	36,934	21,766	20,907	19,019

	May	Jun	Jul	Aug
% EDI Med Claims Paid within 21 Cal. Days	99.1%	65.7%	58.5%	59.4%
Total EDI Medical Claims Paid within 21 Cal. Days	21,303	12,518	11,568	10,888
Total EDI Medical Claims Processed	21,507	19,041	19,768	18,315
% of Paper Medical Claims Paid within 30 Cal. Days	98.0%	97.5%	96.3%	97.2%
Total Paper Medical Claims Paid within 30 Cal. Days	6,503	5,720	6,891	5,482
Total Paper Medical Claims Processed	6,639	5,869	7,159	5,642
% of Pharmacy Claims paid within 21 Cal. Days	58.7%	57.8%	60.1%	58.5%
Total Pharmacy Claims paid within 21 Cal. Days	10,637	9,319	13,331	8,188
Total Pharmacy Claims processed	18,122	16,135	22,168	13,999

	Sep	Oct	Nov	Dec	Total
% EDI Med Claims Paid within 21 Cal. Days	52.0%	58.1%	65.0%	49.2%	78.6%
Total EDI Medical Claims Paid within 21 Cal. Days	8,564	9,988	10,296	7,336	194,825
Total EDI Medical Claims Processed	16,476	17,191	15,848	14,910	247,872
% of Paper Medical Claims Paid within 30 Cal. Days	96.0%	93.1%	97.8%	96.9%	96.8%
Total Paper Medical Claims Paid within 30 Cal. Days	4,817	4,884	4,746	3,904	78,854
Total Paper Medical Claims Processed	5,019	5,246	4,854	4,028	81,496
% of Pharmacy Claims paid within 21 Cal. Days	57.2%	58.2%	58.9%	59.3%	58.8%
Total Pharmacy Claims paid within 21 Cal. Days	7,802	7,781	7,649	11,405	134,259
Total Pharmacy Claims processed	13,631	13,371	12,986	19,236	228,274

Electronic

	2004
Total clean EDI claims processed	247,872
Total clean Pharmacy processed	228,274
Total electronic	476,146
EDI processed within 21 days	194,825
Pharmacy processed within 21 days	134,259
Total electronic processed in 21 days	329,084

329,084/476,146 = sixty-nine and one tenth percent (**69.1%**) of clean electronic claims processed within 21 days

Paper

	2004
Total clean medical claims processed	81,496
Total medical claims processed within 30 days	78,854

78,854/81,496 = ninety-six and eight tenths percent (**96.8%**) of clean paper claims processed within 30 days

Combined

407,938/557,642 = seventy-three and two tenths percent (**73.2%**) of total clean claims processed within time guidelines

Pharmacy claims are administered by Medco Health Solutions, Inc. The Plan paid no interest to providers for clean pharmacy claims not processed within twenty-one (21) calendar days during the year, 2004. Interest was paid on all other clean claims not processed within appropriate timelines.

The Plan discovered that pharmacy and medical claims were not being consistently paid within the twenty-one (21) calendar day timeframe prior to the start of the examination. Medco implemented a system enhancement in April, 2005 which brought the pharmacy claims into compliance by June, 2005. The Plan implemented a system change in the medical claims system January, 2005 which brought the medical claims into compliance in February, 2005.

REPORT SUMMARIZATION

A sample review of three hundred twenty-five (325) files was examined. Thirty-seven (37) errors were found. The following represents general findings; however, specific details are found in each section of the report.

Sample Files Reviewed -- 325

- One hundred (100) HMO policies
- One hundred (125) Complaint files
- One hundred (100) claim files

Findings

- Complaints – thirty (30) errors – page 7 of the report
  - Nine (9) errors – Tenn. Code Ann. § 56-32-210(c)(6). Failure by the Plan to advise the member, upon receipt of the complaint, of his or her right to submit written material and obtain the assistance of any uninvolved member of the staff.
  - Twenty-one (21) errors – Tenn. Code Ann. §§ 56-32-210(c)(5) and 210(c)(7). Failure to review complaints within ten (10) working days of receipt of the complaint; and to issue the covered person a written decision regarding a denied claim within five (5) working days of the date of the review.

- Claims – seven (7) errors – page 8 of the report
  - Tenn. Code Ann. § 56-7-109. Failure to pay or respond to electronic claims within twenty-one (21) days of receipt.

Prompt Payment of Claims

- Review of the clean claim stratification analysis of the year, 2004, indicated that sixty-nine and one tenth percent (69.1%) of total electronic clean claims were processed within twenty-one (21) days. Ninety-six and eight tenths percent (96.8%) of paper claims were paid within thirty (30) days. Compliance with time guidelines for the entire population was seventy-three and two tenths percent (73.2%).

- Tenn. Code Ann. § 56-7-109(c)(2) specifies that:

  If the Commissioner finds a health insurance entity has failed during any calendar year to properly process and pay ninety-five (95%) of all clean claims received from providers during that year in accordance with this section, the commissioner may levy an aggregate penalty up to ten thousand dollars ($10,000). If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay eighty-five percent (85%) of all clean claims received from all providers during that year in accordance with this section, the commissioner may levy an aggregate penalty in an amount of not less than ten thousand dollars ($10,000) nor more than one hundred thousand dollars ($100,000), if reasonable notice in writing is given of the intent to levy the penalty. If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay sixty percent (60%) of all clean claims received from all

providers during that year in accordance with this section, the commissioner may levy an aggregate penalty in an amount of not less than one hundred thousand dollars ($100,000) nor more than two hundred thousand dollars ($200,000).

EXAMINATION REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of United HealthCare of Tennessee, Inc. during the examination are acknowledged.

The undersigned examiners conducted the examination and prepared the report. Also assisting in the examination and preparing of the report, was Keith M. Patterson, Insurance Examiner, The Department of Commerce and Insurance, State of Tennessee.

Respectfully submitted,

Ann M. McClain, CIE, FLMI, FLHC, CCP,
AIRC, AIAA, ARA, AIS, ACS
William A. Dow, III, AIE, FLMI
Edward Chandler

Independent Market Conduct Examiners

AFFIDAVIT

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

Ann M. McClain

Ann M. McClain, CIE, FLMI, FLHC, CCP,
AIRC, AIAA, ARA, AIS, ACS
TaylorChandler, LLC
On behalf of the State of Tennessee
Southeastern Zone, NAIC

Caroll J. Duncan

NOTARY PUBLIC STATE OF TEXAS
CAROLL J. DUNCAN
Notary Public, State of Texas
My Commission Expires
AUGUST 16, 2006

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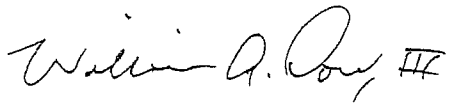

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TaylorChandler, LLC
On behalf of the State of Tennessee
Southeastern Zone, NAIC

EXHIBIT
B

UnitedHealthcare
A UnitedHealth Group Company

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RECEIVED
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Dept. Of Commerce & Insurance
Company Examinations

August 22, 2006

Mr. Don Spann, CFE
State of Tennessee
Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

Subject: **UnitedHealthcare of Tennessee, Inc. Market Conduct Examination Response to August 9, 2006 Examination Report**

Thank you for the opportunity to review the August 9, 2006 draft of the Examination Report for UnitedHealthcare of Tennessee, Inc. The Company has the following additional comment which we are detailing below:

- **Page 9, Complaints Received By The Tennessee Department of Commerce and Insurance- Sample Review Findings, Fourth Paragraph:**
  The report states that there were five (5) claims reported to the Division of Consumer Insurance Services for which the Company had made no response. The Company has no knowledge of which five (5) complaints are being referred to in the report or of any late responses to them. The Company therefore cannot confirm or deny the Department's statement.

With the exception of the above comment, the Company agrees that this Examination Report accurately represents our position. Please feel free to contact me if you should have any questions, or comments.

Sincerely,

Eric Campbell

Eric W. Campbell

cc: Jean Boord