

**FORM A STATEMENT
REGARDING THE
ACQUISITION OF CONTROL OF A DOMESTIC INSURER
ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION,
INCORPORATED
a Colorado health maintenance organization**

**AND
ROCKY MOUNTAIN HEALTHCARE OPTIONS, INC.
a Colorado non-profit hospital, medical-surgical and health services corporation
(Names of Domestic Insurance Entities)**

**BY
UNITEDHEALTH GROUP INCORPORATED,
9900 Bren Road East
Minnetonka, Minnesota 55343,
A Delaware corporation**

**AND
UNITED HEALTHCARE SERVICES, INC.,
9900 Bren Road East
Minnetonka, Minnesota 55343
A Minnesota corporation
(Names of Applicants)**

Filed with the Colorado Division of Insurance

Dated: August 3, 2016

Name, title, address, and telephone number of individuals to whom notices and correspondence concerning this Statement should be addressed:

Michael N. Molepske
Senior Associate General Counsel
UnitedHealth Group Incorporated
9900 Bren Road East, MN008-T700
Minnetonka, Minnesota 55343
Telephone: (952) 936-6501
Email: michael.molepske@uhg.com

with a copy to:

Scott M. Kosnoff and Sara M. Powell
Faegre Baker Daniels LLP
300 North Meridian Street, Suite 2700
Indianapolis, IN 46204
Telephone: (317) 237-1201 and (317) 237-1186
Facsimile: (317) 237-1000
Email: scott.kosnoff@faegrebd.com and sara.powell@faegrebd.com

This Statement Regarding the Acquisition of Control of a Domestic Insurer (this “Statement”) is submitted to the Colorado Department of Regulatory Agencies Division of Insurance (“CDI”) by UnitedHealth Group Incorporated, a Delaware corporation (“UHG”), and United HealthCare Services, Inc., a Minnesota corporation and a direct wholly-owned subsidiary of UHG (“UHS”) (together with UHG, the “Applicants”), in connection with the proposed acquisition of Rocky Mountain Health Maintenance Organization, Incorporated, a Colorado non-profit corporation authorized to operate as a health maintenance organization (“RMHMO”) and Rocky Mountain HealthCare Options, Inc., a Colorado non-profit corporation authorized to operate as a nonprofit hospital, medical-surgical and health services corporation (individually, “RMHCO” and together with RMHMO, the “Insurance Entities”), pursuant to a Stock Purchase Agreement dated July 22, 2016 (the “Agreement”) more particularly described below and attached as Exhibit 1.¹

ITEM 1. METHOD OF ACQUISITION

The name and address of the Insurance Entities to which this Statement relates is as follows:

Rocky Mountain Health Maintenance Organization, Incorporated
2775 Crossroads Boulevard
Grand Junction, CO 81506-8712

Rocky Mountain HealthCare Options, Inc.
2775 Crossroads Boulevard
Grand Junction, CO 81506-8712

The federal identification number of RMHMO is 84-0614905, and the NAIC number of RMHMO 95482. The federal identification number of RMHCO is 84-1224718, and the NAIC number of RMHCO 47004.

RMHMO provides managed care coverage to employers and individuals, including to Medicare, Medicaid and Child Health Plan Plus beneficiaries. It is the sole member of RMHCO. RMHCO provides indemnity products with managed care features that complement the health contracts offered by RMHMO. A pre-acquisition organizational chart for the Insurance Entities and their affiliates is attached as Exhibit 2.

Under the Agreement, prior to the Closing, RMHMO will convert from a tax-exempt, non-profit Colorado corporation to a taxable, for-profit Colorado corporation (the “Conversion”). Immediately following the effectiveness of the Conversion, Rocky Mountain Health Plans Foundation (the “Seller”) will own all of the issued and outstanding shares of capital stock of RMHMO and will, by virtue of its ownership interest in RMHMO, indirectly own all of the

¹ Exhibit C to the Agreement contains confidential information and is being separately filed in a sealed envelope marked “Confidential.” The Applicants request that (i) Exhibit C to the Agreement be afforded confidential treatment because its public disclosure would cause substantial harm to RMHMO and RMHCO by allowing competitors to obtain nonpublic commercial and financial information, (ii) the Applicants be notified in advance of any proposed disclosure by the CDI, and (iii) the Applicants be given a reasonable opportunity to seek a protective order or take other action to prevent or limit any such disclosure.

issued and outstanding membership interests of RMHCO. Subject to the terms and conditions set forth in the Agreement, following the effectiveness of the Conversion, and conditioned upon attaining necessary regulatory approvals, UHS will acquire from Seller all of the issued and outstanding shares of capital stock of RMHMO. By virtue of acquiring all of the issued and outstanding capital stock of RMHMO, UHS will own 100% of the membership interests of RMHCO.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

Name and Address of Applicants

The names and addresses of the Applicants seeking to acquire control of the Insurance Entities are:

UnitedHealth Group Incorporated
9900 Bren Road East
Minnetonka, Minnesota 55343

and

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, Minnesota 55343

Nature of the Applicants' Businesses

UHG was incorporated on January 25, 1977 as a Minnesota general business corporation and functions primarily as a holding company. On July 1, 2015, UHG changed its state of incorporation from Minnesota to Delaware pursuant to a plan of conversion. The reincorporation was a tax-free reorganization under the U.S. Internal Revenue Code and did not affect UHG's business operations. UHG currently has a long term issuer credit rating from S&P of "A+," a rating from Moody's Investors Services of "A3," a rating from Fitch of "A-," and a rating from A.M. Best Company of "bbb+."

Overview

UHG is a diversified health and well-being company dedicated to helping people live healthier lives and making the health system work better for everyone. The terms "we," "our," "us," "its," or the "Company" in this section refer to UHG and its subsidiaries.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and clinical care management and coordination to help meet the demands of the health system. 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 pharmacy care services and information and technology-enabled health services.

UnitedHealthcare provides health care benefits to an array of customers and markets. UnitedHealthcare Employer & Individual serves employers ranging from sole proprietorships to large, multi-site and national employers, public sector employers and other individuals and serves the nation's active and retired military and their families through the TRICARE program. UnitedHealthcare Medicare & Retirement delivers health and well-being benefits for Medicare beneficiaries and retirees. UnitedHealthcare Community & State manages health care benefit programs on behalf of state Medicaid and community programs and their participants. UnitedHealthcare Global includes Amil, a health care company providing health and dental benefits and hospital and clinical services to employer groups and individuals in Brazil, and other diversified global health businesses.

Optum is a health services business serving the broad health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers, through its OptumHealth, OptumInsight and OptumRx businesses. These businesses have dedicated units that help improve overall health system performance through optimizing care quality, reducing costs and improving consumer experience and care provider performance across eight business markets: care delivery, care management, pharmacy care services, consumer engagement, distribution, health financial services, health care information technology and operational services and support.

Through UnitedHealthcare and Optum, in 2015, we managed nearly \$200 billion in aggregate health care spending on behalf of the customers and consumers we serve. Our revenues are derived from premiums on risk-based products; fees from management, administrative, technology and consulting services; sales of a wide variety of products and services related to the broad health and well-being industry; and investment and other income. Our two business platforms have four reportable segments:

- UnitedHealthcare, which includes UnitedHealthcare Employer & Individual, UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State and UnitedHealthcare Global;
- OptumHealth;
- OptumInsight; and
- OptumRx.

A detailed description of UHG's four business segments is set out below.

UnitedHealthcare

Through its health benefits offerings, UnitedHealthcare is enabling better health, helping to control rising health care costs and creating a better health care experience for its customers. UnitedHealthcare's market position is built on:

- a national scale;
- strong local market relationships;
- the breadth of product offerings, which are responsive to many distinct market segments in health care;

- service and advanced technology;
- competitive medical and operating cost positions;
- effective clinical engagement;
- extensive expertise in distinct market segments; and
- innovation for customers and consumers.

UnitedHealthcare utilizes Optum's capabilities to help coordinate patient care, improve affordability of medical care, analyze cost trends, manage pharmacy benefits, work with care providers more effectively and create a simpler consumer experience.

In the United States, UnitedHealthcare arranges for discounted access to care through networks that include 1 million physicians and other health care professionals and approximately 6,000 hospitals and other facilities.

UnitedHealthcare Employer & Individual

UnitedHealthcare Employer & Individual offers an array of consumer-oriented health benefit plans and services nationwide for large national employers, public sector employers, mid-sized employers, small businesses, individuals and military service members in the TRICARE west region. UnitedHealthcare Employer & Individual provides access to medical services for approximately 30 million people on behalf of our customers and alliance partners. This includes more than 190,000 employer customers across all 50 states. Large employer groups typically use self-funded arrangements where UnitedHealthcare Employer & Individual earns a service fee. Smaller employer groups and individuals are more likely to purchase risk-based products because they are less willing or unable to bear a greater potential liability for health care expenditures.

Through its risk-based product offerings, UnitedHealthcare Employer & Individual assumes the risk of both medical and administrative costs for its customers in return for a monthly premium, which is typically a fixed rate per individual served for a one-year period. When providing administrative and other management services to customers that elect to self-fund the health care costs of their employees and employees' dependents, UnitedHealthcare Employer & Individual receives a fixed monthly service fee per individual served. These customers retain the risk of financing medical benefits for their employees and employees' dependents, while UnitedHealthcare Employer & Individual provides services such as coordination and facilitation of medical and related services to customers, consumers and health care professionals, administration of transaction processing and access to a contracted network of physicians, hospitals and other health care professionals, including dental and vision. UnitedHealthcare Employer & Individual also offers a variety of insurance options for purchase by individuals, including students, which are designed to meet the health coverage needs of these consumers and their families.

The consolidated purchasing capacity represented by the individuals UnitedHealth Group serves makes it possible for UnitedHealthcare Employer & Individual to contract for cost-effective access to a large number of conveniently located care professionals and facilities.

UnitedHealthcare Employer & Individual's UnitedHealth Premium® program is the longest-running physician quality and efficiency designation program in the industry, making it easier for consumers to access high-quality, cost-efficient care. UnitedHealthcare Employer & Individual has relationships with network care providers that integrate data and analytics, implement value-based payments and care management programs, and enable us to jointly better manage health care across populations.

UnitedHealthcare Employer & Individual typically distributes its products through consultants or direct sales in the larger employer and public sector segments. In the smaller group segment of the commercial marketplace, UnitedHealthcare Employer & Individual's distribution system consists primarily of direct sales and sales through collaboration with brokers and agents. UnitedHealthcare Employer & Individual also distributes products through wholesale agents or agencies that contract with health insurance carriers to distribute individual or group benefits and provide other related services to their customers.

UnitedHealthcare Employer & Individual also distributes its products through professional employer organizations, associations, private equity relationships and, increasingly, through both multi-carrier and its own proprietary private exchange marketplaces. UnitedHealthcare Marketplace is a shopping platform for employers seeking to offer their employees flexibility and a choice of UnitedHealthcare plans. UnitedHealthcare Employer & Individual is also participating in select multi-plan exchanges that are structured to encourage consumer choice. Direct-to-consumer sales are also supported by participation in multi-carrier health insurance marketplaces for individuals and small groups through exchanges.

UnitedHealthcare Employer & Individual's diverse product portfolio offers a continuum of benefit designs, price points and approaches to consumer engagement, which provides the flexibility to meet the needs of employers of all sizes, as well as the needs of individuals shopping for health benefits coverage. Cost pressures are accelerating demand for improved health care affordability and more coordinated care. UnitedHealthcare Employer & Individual is responding to this demand with new network and contracting constructs (such as performance incentives and benefit designs that direct more patients to higher-performing care providers), alternative access to affordable and convenient care (such as through telehealth appointments with registered nurses and physicians) and a new consumer-responsive service model called Advocate4Me.

UnitedHealthcare Employer & Individual offers its products through affiliates that are licensed as insurance companies, health maintenance organizations (HMOs), or third-party administrators (TPAs). The market for health benefit products is shifting, with benefit and network offerings shaped, at least in part, by the requirements and effects of the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (together, Health Reform Legislation), increased employer focus on quality and employee engagement and the urgent need to align the system around value.

Employers are seeking to offer comprehensive health benefits that improve the health and wellness of their populations and as a result, lower overall health care costs, while improving employee satisfaction. By promoting a healthy workforce, employers can maximize productivity

and lower overall health care costs. UnitedHealthcare Employer & Individual offers affordable products and actionable information to enable better health outcomes and to help employers attract and retain talent. UnitedHealthcare Employer & Individual's major product families include:

Traditional Products. Traditional products include a full range of medical benefits and network options from managed plans, such as Choice and Options PPO, to more traditional indemnity products. The plans offer a full spectrum of covered services, including preventive care, direct access to specialists and catastrophic protection.

Consumer Engagement Products. Consumer engagement products couple plan design with financial accounts to increase individuals' responsibility for their health and well-being. This suite of products includes high-deductible consumer-driven benefit plans, which include health reimbursement accounts (HRAs), health savings accounts (HSAs) and consumer engagement services such as personalized behavioral incentive programs and consumer education. During 2015, nearly 35,000 employer-sponsored benefit plans, including nearly 400 employers in the large group self-funded market, purchased HRA or HSA products from us.

Clinical and Pharmacy Products. UnitedHealthcare Employer & Individual offers a comprehensive suite of clinical and pharmacy benefits management products, which complement its service offerings by improving quality of care, engaging members and providing cost-saving options. All UnitedHealthcare Employer & Individual members are provided access to clinical products that help them make better health care decisions and better use of their medical benefits, which contribute to improved health and lowered medical expenses.

Each medical plan has a core set of clinical programs embedded in the offering, with additional services available depending on funding type (fully insured or self-funded), line of business (e.g., small business, key accounts, public sector, national accounts or individuals) and clinical need. UnitedHealthcare Employer & Individual's clinical programs include:

- wellness programs;
- decision support;
- utilization management;
- case and disease management;
- complex condition management;
- on-site programs, including Know Your Numbers (biometrics) and flu shots;
- incentives to reinforce positive behavior change;
- mental health/substance use disorder management; and
- employee assistance programs.

UnitedHealthcare Employer & Individual's comprehensive and integrated pharmaceutical management services promote lower costs by using formulary programs to produce better unit costs, encouraging consumers to use drugs that offer improved value and outcomes and

supporting the appropriate use of drugs based on clinical evidence through physician and consumer education programs.

Specialty Offerings. UnitedHealthcare Employer & Individual also delivers dental, vision, life and disability product offerings through an integrated approach, including a network of more than 22,000 vision offices and more than 80,000 dental offices, in private and retail settings.

UnitedHealthcare Military & Veterans. UnitedHealthcare Military & Veterans' responsibility as a contractor is to augment the military's direct care system by providing managed care support services, provider networks, medical management, claims/enrollment administration and customer service. UnitedHealthcare Military & Veterans is the provider of health care services for nearly 3 million active duty and retired military service members and their families in 21 states under the Department of Defense's (DoD) TRICARE Managed Care Support contract. The contract began on April 1, 2013. The DoD is moving from three to two regions for 2017. The government intends to make a decision in the spring of 2016, for contracts to begin delivering services on or about April 1, 2017. UnitedHealthcare Military & Veterans has submitted bids to offer services under the new contracts.

UnitedHealthcare Medicare & Retirement

UnitedHealthcare Medicare & Retirement provides health and well-being services to individuals age 50 and older, addressing their unique needs for preventive and acute health care services, as well as services dealing with chronic disease and other specialized issues common among older individuals. UnitedHealthcare Medicare & Retirement is fully dedicated to serving this growing senior market segment, providing products and services in all 50 states, the District of Columbia and most U.S. territories. UnitedHealthcare Medicare & Retirement has distinct pricing, underwriting, clinical program management and marketing capabilities dedicated to health products and services in this market.

UnitedHealthcare Medicare & Retirement offers a selection of products that allow people to obtain the health coverage and services they need as their circumstances change. UnitedHealthcare Medicare & Retirement is positioned to serve seniors who find that affordable, network-based care provided through Medicare Advantage plans meets their unique health care needs. For those who prefer traditional fee-for-service Medicare, UnitedHealthcare Medicare & Retirement offers both Medicare Supplement and Medicare Prescription Drug Benefit (Medicare Part D) prescription drug programs that supplement their government-sponsored Medicare by providing additional benefits and coverage options. Beneficiaries with special needs are served through UnitedHealthcare Medicare & Retirement Dual, Chronic and Institutional Special Needs Plans (SNPs) in many markets. UnitedHealthcare Medicare & Retirement services include care management and clinical management programs, a nurse health line service, 24-hour access to health care information, access to discounted health services from a network of care providers and administrative services.

UnitedHealthcare Medicare & Retirement's seniors-focused care management model enables it to operate at a medical cost level below that of traditional Medicare. This model is based on more than 20 years of expertise in chronic disease care management, underpinned by a proprietary technology platform. These capabilities help improve the health and well-being of

older, disabled or otherwise vulnerable individuals. For example, through UnitedHealth Group's HouseCalls program, nurse practitioners performed approximately 1 million in-home preventative care visits in 2015 to identify, document and help close gaps in care for seniors.

Premium revenues from the Centers for Medicare & Medicaid Services (CMS) represented 26% of UnitedHealth Group's total consolidated revenues for the year ended December 31, 2015, most of which were generated by UnitedHealthcare Medicare & Retirement.

UnitedHealthcare Medicare & Retirement has extensive distribution capabilities and experience, including direct marketing to consumers on behalf of its key clients: AARP, the nation's largest membership organization dedicated to the needs of people age 50 and over, and state and U.S. government agencies. Products are also offered through employer groups and agent channels.

UnitedHealthcare Medicare & Retirement's major product categories include:

Medicare Advantage. UnitedHealthcare Medicare & Retirement provides health care coverage for seniors and other eligible Medicare beneficiaries primarily through the Medicare Advantage program administered by CMS, including Medicare Advantage HMO plans, preferred provider organization (PPO) plans, Point-of-Service plans, Private-Fee-for-Service plans and SNPs. Under the Medicare Advantage program, UnitedHealthcare Medicare & Retirement provides health insurance coverage in exchange for a fixed monthly premium per member from CMS plus, in some cases, consumer premiums. Premium amounts received from CMS vary based on the geographic areas in which members reside; demographic factors such as age, gender and institutionalized status; and the health status of the individual. UnitedHealthcare Medicare & Retirement served more than 3 million people through its Medicare Advantage products as of December 31, 2015.

Medicare Advantage plans are designed to compete at the local level, taking into account member and care provider preferences, competitor offerings, our historical financial results, our quality and cost initiatives and the long-term payment rate outlook for each geographic area. Starting in 2012, and phased in through 2017, the Medicare Advantage rate structure and quality rating bonuses are changing significantly.

UnitedHealthcare Medicare & Retirement offers innovative care management, disease management and other clinical programs, integrating federal, state and personal funding through its continuum of Medicare Advantage products. For high-risk patients in certain care settings and programs, UnitedHealthcare Medicare & Retirement uses proprietary, automated medical record software that enables clinical care teams to capture and track patient data and clinical encounters, creating a comprehensive set of care information that bridges across home, hospital and nursing home care settings. Proprietary predictive modeling tools help identify members at high risk and allow care managers to reach out to those members and create individualized care plans that help them obtain the right care, in the right place, at the right time.

Medicare Part D. UnitedHealthcare Medicare & Retirement provides Medicare Part D benefits to beneficiaries throughout the United States and its territories through its Medicare Advantage and stand-alone Medicare Part D plans. UnitedHealthcare Medicare & Retirement offers two

stand-alone Medicare Part D plans: the AARP MedicareRx Preferred and the AARP MedicareRx Saver Plus plans. The stand-alone Medicare Part D plans address a large spectrum of beneficiaries' needs and preferences for their prescription drug coverage, including low cost prescription options. Each of the plans includes the majority of the drugs covered by Medicare and provides varying levels of coverage to meet the diverse needs of Medicare beneficiaries. As of December 31, 2015, UnitedHealthcare enrolled more than 8 million people in the Medicare Part D programs, including more than 5 million individuals in the stand-alone Medicare Part D plans and more than 3 million in Medicare Advantage plans incorporating Medicare Part D coverage.

Medicare Supplement. UnitedHealthcare Medicare & Retirement is currently serving more than 4 million seniors nationwide through various Medicare Supplement products in association with AARP. UnitedHealthcare Medicare & Retirement offers a full range of supplemental products at diverse price points. These products cover the various levels of coinsurance and deductible gaps that seniors are exposed to in the traditional Medicare program.

UnitedHealthcare Community & State

UnitedHealthcare Community & State is dedicated to serving state programs that care for the economically disadvantaged, the medically underserved and those without the benefit of employer-funded health care coverage, in exchange for a monthly premium per member from the state program. In some cases, these premiums are subject to experience or risk adjustments. UnitedHealthcare Community & State's primary customers oversee Medicaid plans, Children's Health Insurance Programs (CHIP), SNPs, integrated Medicare-Medicaid plans (MMP) and other federal, state and community health care programs. As of December 31, 2015, UnitedHealthcare Community & State participated in programs in 24 states and the District of Columbia, and served more than 5 million beneficiaries. Health Reform Legislation provided for optional Medicaid expansion effective January 1, 2014. Currently, UnitedHealthcare Community & State serves people through Medicaid expansion programs in 13 states.

States using managed care services for Medicaid beneficiaries select health plans by using a formal bid process or by awarding individual contracts. A number of factors are considered by UnitedHealthcare Community & State when choosing programs for participation, including the state's commitment and consistency of support for its Medicaid managed care program in terms of service, innovation and funding; the eligible population base, both immediate and long term; and the structure of the projected program. UnitedHealthcare Community & State works with its state customers to advocate for actuarially sound rates that are commensurate with medical cost trends.

The primary categories of eligibility for the programs served by UnitedHealthcare Community & State and its participation are:

- Temporary Assistance to Needy Families, primarily women and children – 21 markets;
- CHIP – 21 markets;
- Aged, Blind and Disabled (ABD) – 19 markets;
- SNP – 14 markets;

- Medicaid Expansion – 13 markets;
- Long-Term Services and Supports (LTSS) – 11 markets;
- childless adults programs for the uninsured – 3 markets;
- other programs (e.g., developmentally disabled, rehabilitative services) – 6 markets; and
- MMP – 2 markets.

These health plans and care programs offered are designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with a higher risk of medical, behavioral and social conditions. UnitedHealthcare Community & State administers benefits for the unique needs of children, pregnant women, adults, seniors and those who are institutionalized or are nursing home eligible. These individuals often live in areas that are medically underserved and are less likely to have a consistent relationship with the medical community or a care provider. These individuals also tend to face significant social and economic challenges.

UnitedHealthcare Community & State leverages the national capabilities of UnitedHealth Group locally, supporting effective care management, strong regulatory partnerships, greater administrative efficiency, improved clinical outcomes and the ability to adapt to a changing national and local market environment. UnitedHealthcare Community & State coordinates resources among family, physicians, other health care providers, and government and community-based agencies and organizations to facilitate continuous and effective care.

The LTSS market represents only 6% of the total Medicaid population, yet accounts for more than 30% of total Medicaid expenditures. The LTSS population is made up of 3 million individuals who qualify for additional benefits under LTSS programs and represent a subset of the 16 million ABD Americans. Currently, 25% of the ABD population and 28% of the LTSS eligible population are served by comprehensive risk-based managed care programs. States are increasingly looking for solutions to not only help control costs, but to improve quality for the complex medical challenges faced by this population and are moving with greater speed to managed care programs.

There are more than 10 million individuals eligible for both Medicare and Medicaid. MMP beneficiaries typically have complex conditions with costs of care that are far higher than typical Medicare or Medicaid beneficiaries. While these individuals' health needs are more complex and more costly, they have been historically served in unmanaged environments. This market provides UnitedHealthcare an opportunity to integrate Medicare and Medicaid funding and improve people's health status through close coordination of care. While dual eligibles account for just 15% of the total Medicaid population, they account for approximately 35% of total Medicaid spending. As of December 31, 2015, UnitedHealthcare served nearly 350,000 people with complex conditions similar to those in an MMP population in legacy programs through Medicare Advantage dual SNPs and UnitedHealthcare Community & State served 24,000 people through MMP programs in Ohio and Texas.

UnitedHealthcare Global

UnitedHealthcare Global participates in international markets through national “in country” and cross-border strategic approaches. UnitedHealthcare Global’s cross-border health care business provides comprehensive health benefits, care management and care delivery for multinational employers, governments and individuals around the world. UnitedHealthcare Global’s goal is to create business solutions that are based on local expertise, infrastructure, culture and needs. As of December 31, 2015, UnitedHealthcare Global provided medical benefits to more than 4 million people, principally in Brazil, but also residing in more than 125 other countries.

Amil. Amil provides medical and dental benefits to more than 5 million people. Amil operates hospitals and specialty, primary care and emergency services clinics across Brazil, principally for the benefit of its members. Amil’s patients are also treated in its contracted provider network of more than 26,000 physicians and other health care professionals, approximately 2,100 hospitals and nearly 8,000 laboratories and diagnostic imaging centers. Amil offers a diversified product portfolio with a wide range of product offerings, benefit designs, price points and value, including indemnity products. Amil’s products include various administrative services such as network access and administration, care management and personal health services and claims processing.

Other Operations. UnitedHealthcare Global includes other diversified global health services operations with a variety of offerings for international customers, including:

- network access and care coordination in the United States and overseas;
- TPA products and services for health plans and TPAs;
- brokerage services;
- practice management services for care providers;
- government and corporate consulting services for improving quality and efficiency; and
- global expatriate insurance solutions.

Optum

Optum is a health services business serving the broad health care marketplace, including:

- Those who need care: the consumers who need the right support, information, resources and products to achieve their health goals.
- Those who provide care: pharmacies, hospitals, physicians’ and other care providers’ practices and other health care facilities seeking to modernize the health system and support the best possible patient care and experiences.
- Those who pay for care: health plans, employers, state, federal and municipal agencies, governmental departments and nonprofit associations devoted to ensuring the populations they sponsor receive high-quality care, administered and delivered efficiently and effectively.

- Those who innovate for care: global life sciences organizations dedicated to developing more effective approaches to care, enabling technologies and medicines that improve care delivery and health outcomes.

Optum is organized in three reportable segments which focus on eight business markets to achieve its full potential for growth and leadership in the health services sector:

- OptumHealth focuses on care delivery, care management, wellness and consumer engagement, distribution and health financial services;
- OptumInsight delivers operational services and support and health care information technology services; and
- OptumRx specializes in pharmacy care services.

OptumHealth

OptumHealth is a diversified health and wellness business serving the physical, emotional and health-related financial needs of more than 78 million unique individuals. OptumHealth enables population health management through programs offered by employers, payers, government entities and, increasingly, directly with the care delivery system. OptumHealth products and services deliver value by improving quality and patient satisfaction while lowering cost. OptumHealth builds high-performing networks and centers of excellence across the care continuum, by working directly with physicians to advance population health management and by coordinating care for the most medically complex patients.

OptumHealth offers its products on a risk basis, where it assumes responsibility for health care costs in exchange for a monthly premium per individual served, and on an administrative fee basis, under which it manages or administers delivery of the products or services in exchange for a fixed monthly fee per individual served. For its financial services offerings, OptumHealth charges fees and earns investment income on managed funds.

OptumHealth sells its products primarily through its direct sales force, strategic collaborations and external producers in three markets: employers (which includes the sub-markets of large, mid-sized and small employers), payers (which includes the sub-markets of health plans, TPAs, underwriter/stop-loss carriers and individual market intermediaries) and government entities (which includes states, CMS, DoD, the Veterans Administration and other federal procurement agencies). As provider reimbursement models evolve, care providers are emerging as a fourth market for the health management, financial services and local care delivery businesses.

OptumHealth is organized into two primary operating groups: OptumCare and Optum Consumer Solutions (OCS).

OptumCare

- OptumCare partners closely with care providers to improve both the health of the populations they serve and the efficiency and cost-effectiveness of local care systems. Through networks comprised of employed, managed and contracted physicians, advanced practitioners and other providers, OptumCare assists care providers in adopting new approaches and technologies that improve collaboration and coordination among

everyone involved in patient care. OptumCare also enables care providers' transition from traditional, fee-for-service care delivery to performance-based delivery and payment models that put patient health and outcomes first, such as those emerging through accountable care organizations (ACOs) and local care provider partnerships. OptumCare builds partnerships with care providers who share its focus on creating strong and sustainable new approaches to care delivery and works with them to develop and deliver services around the spectrum of patient and community needs.

- **Mobile Care Delivery.** OptumCare's mobile care delivery business provides occupational health, medical and dental readiness services, treatments and immunization programs. These solutions serve a number of government and commercial clients, including the U.S. military.

OCS.

- **Population Health Management Services:** OCS serves people through population health management services that meet both the preventative care and health intervention needs of consumers across the care continuum - physical health and wellness, mental health, complex medical conditions, disease management, hospitalization and post-acute care. This includes offering access to proprietary networks of provider specialists in many clinical specialties, including behavioral health, organ transplant, chiropractic and physical therapy. OCS engages consumers in managing their health, including guidance, tools and programs that help them achieve their health goals and maintain healthy lifestyles.
- **Distribution:** This business provides sales and services through digital, phone and in-person interaction to assist individuals in selecting and understanding their benefits. OCS provides contact center support, multimodal software, data analysis and licensed sales agents that help clients acquire, retain and service large populations of health care consumers.
- **Financial Services:** This business provides a range of health care financial products for individuals, employers, health care professionals and payers. OCS is a leading provider of consumer health care accounts. OCS also offers electronic claims payment services to care providers through Optum Bank, a wholly-owned subsidiary, with more than 3.8 million accounts and \$4.2 billion in assets under management as of December 31, 2015. During 2015, Optum Bank processed more than \$100 billion in medical payments to physicians and other health care providers.

OptumInsight

OptumInsight provides services, technology and health care expertise to major participants in the health care industry. OptumInsight's capabilities are focused on modernizing the health system through technology, analytics and information that help drive higher quality and greater efficiency in the health care system. Hospital systems, physician practices, commercial health plans, government agencies, life sciences companies and other organizations that comprise the health care system depend on OptumInsight to help them improve performance, achieve efficiency, reduce costs, meet compliance mandates and modernize their core operating systems to meet the changing needs of the health system.

Many of OptumInsight's software and information products, advisory consulting arrangements and outsourcing contracts are delivered over an extended period, often several years. OptumInsight maintains an order backlog to track unearned revenues under these long-term arrangements. The backlog consists of estimated revenue from signed contracts, other legally binding agreements and anticipated contract renewals based on historical experience with OptumInsight's customers. OptumInsight's aggregate backlog at December 31, 2015, was \$10.4 billion, of which \$5.9 billion is expected to be realized within the next 12 months. This includes \$3.8 billion related to intersegment agreements, all of which are included in the current portion of the backlog. OptumInsight's aggregate backlog at December 31, 2014, was \$8.6 billion. OptumInsight cannot provide any assurance that it will be able to realize all of the revenues included in the backlog due to uncertainties with regard to the timing and scope of services and the potential for cancellation, non-renewal or early termination of service arrangements.

OptumInsight's products and services are sold primarily through a direct sales force. OptumInsight's products are also supported and distributed through an array of alliances and business partnerships with other technology vendors, who integrate and interface OptumInsight's products with their applications.

OptumInsight provides capabilities targeted to the needs of four primary market segments: care providers (e.g., physician practices and hospital systems), payers, governments and life sciences organizations.

Care Providers. Serving five out of six U.S. hospitals and tens of thousands of physician practices, OptumInsight provides capabilities that help drive financial performance, meet compliance requirements and deliver health intelligence. OptumInsight brings an array of solutions to help care providers, with particular focus on clinical performance and quality improvement, population health management, data management and analytics, revenue management, cost containment, compliance, cloud-enabled collaboration and consumer engagement.

Payers. OptumInsight serves approximately 300 health plans by helping them improve operational and administrative efficiency, understand and optimize growth while managing risk, deliver on clinical performance and compliance goals and build and manage strong provider networks. OptumInsight is also helping payer clients adapt to new market models, including health insurance exchanges, consumer-driven health care and engagement, pay-for-value contracting and population health management.

Governments. OptumInsight provides services to federal and state government clients that are tailored to them as government payers, including data and analytics technology, claims management and payment accuracy services and strategic consulting. In addition, OptumInsight provides custom system integration expertise and services to meet complex government needs, including public health insurance exchanges.

Life Sciences. OptumInsight provides services to global life sciences organizations. These companies look to OptumInsight for data analytics and expertise in core areas of health

economics and outcomes research; market access and reimbursement consulting; integrated clinical and health care claims data and informatics services; epidemiology and drug safety; and patient reported outcomes.

OptumRx

OptumRx provides a full spectrum of pharmacy care services to more than 66 million people in the United States through its network of more than 67,000 retail pharmacies and multiple home delivery facilities throughout the country. In 2016, OptumRx expects to manage nearly \$80 billion in pharmaceutical spending, including more than \$28 billion in specialty pharmaceutical spending. OptumRx's pharmacy care services deliver a low-cost, high-quality pharmacy benefit through retail network contracting, including rebate management and clinical programs such as step therapy, formulary management, drug adherence and disease/drug therapy management programs.

The 2015 acquisition of Catamaran Corporation (Catamaran) allows OptumRx to better serve more people. OptumRx's comprehensive whole-person approach integrates demographic, medical, pharmaceutical and other clinical data and then applies analytics to drive clinical care insight to support care treatments and compliance, benefiting clients and individuals through enhanced services and cost trend management. These enhancements will be driven by advanced technology, augmented resources and greater efficiencies and cost containment strategies through increased scale.

OptumRx provides pharmacy care services to a substantial majority of UnitedHealthcare members. Additionally, OptumRx manages specialty pharmacy benefits across nearly all of UnitedHealthcare's businesses with services, including patient support and clinical programs designed to ensure quality and deliver value for consumers. OptumRx also provides pharmacy care services to non-affiliated external clients, including a number of health plans, large national employer plans, unions and trusts and government entities. These clients rely on OptumRx for components or all of their pharmacy care services. OptumRx's distribution system consists primarily of health insurance brokers and other health care consultants and direct sales.

Business Intended to Be Done by the Applicants

The Applicants intend to continue their present business activities in the future.

UHS

UHS is a Minnesota corporation and a wholly owned subsidiary of UHG. UHS provides management services to health care companies and is widely licensed as a third party administrator and a utilization review agent.

Organizational Chart

The organizational charts attached hereto as Exhibit 3 and Exhibit 4 present the identities of and the inter-relationships among the Applicants and affiliates prior to and following the proposed acquisition. Such charts indicate the percentage of voting securities of each entity owned or

controlled by the Applicants or by any other such entity as well as the type of organization and the state or other jurisdiction of domicile of each entity specified therein. Unless otherwise indicated on such charts or in this Statement, each entity is a corporation and control is maintained by the ownership or control of voting securities. No court proceeding involving a reorganization or liquidation is pending with respect to the Applicants or any of their affiliates.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH APPLICANT

A list of the directors and executive officers of UHG and UHS is attached as Exhibit 5. The business addresses, principal business activities, material occupations, positions, offices or employment during the last five years of the directors and executive officers of UHG and UHS are stated in the biographical affidavits for such persons, which are being filed as Exhibit 6. Except as set forth in such biographical affidavits, no such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency. The current status of any such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith, are stated in such biographical affidavits.

Except as otherwise indicated in Exhibit 6, to the best knowledge, information and belief of the Applicants, no director or executive officer of UHG or UHS has been convicted in a criminal proceeding (excluding minor traffic violations) during the past ten years. To UHG's knowledge, there are no shareholders holding 10% or more of UHG's voting securities.

The biographical affidavits for the directors and executive officers of UHG and UHS provided in Exhibit 6 contain confidential information. They are marked "CONFIDENTIAL" and are being separately filed in a sealed envelope marked "Confidential." The Applicants request that (i) the biographical affidavits be afforded confidential treatment in order to avoid unwarranted invasions of personal privacy, (ii) the Applicants be notified in advance of any proposed disclosure of the biographical affidavits by the CDI, and (iii) the Applicants be given a reasonable opportunity to seek a protective order or take other action to prevent or limit any such disclosure.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

Nature, Source and Amount of Funds or Other Consideration Used or to Be Used in Effecting the Acquisition

Source and Amount of Consideration

UHS will acquire all of the issued and outstanding shares of capital stock of RMHMO for a purchase price to be determined in accordance with Section 2.5 of the Agreement. As of the date of this Statement, the purchase price is estimated to be \$36,500,000. The purchase price will be financed with cash on hand. Seller will transfer its shares of RMHMO to UHS at the closing.

Debt Financing or Borrowing

The purchase price will be financed with cash on hand. No portion of the purchase price consists of consideration borrowed or otherwise obtained for the purpose of effecting the proposed acquisition.

Criteria Used in Determining the Nature and Amount of Such Consideration

The Applicants performed a comprehensive due diligence investigation and reviewed, among other things, the financial statements, operations, and legal documents of the Insurance Entities and their affiliates. The Applicants utilized widely accepted valuation techniques, including discounted cash flow and guideline company methodologies, to obtain an indication of value for determining the amount of consideration and also considered such additional factors and information as the Applicants deemed relevant under the circumstances. The basis and terms of the acquisition, including the consideration, resulted from arm's length negotiations between the management and representatives of the Applicants and the Seller.

Identities of the Lenders

Not applicable.

ITEM 5. FUTURE PLANS OF INSURER

The Applicants share the Insurance Entities' commitment to the regional community and its citizens. To demonstrate that commitment, within 10 days of the closing, UHS will make a capital contribution to RMHMO that will increase the Company's Total Adjusted Capital to 300% of its Authorized Control Level RBC. The capital contribution will be financed with cash on hand. This will help ensure that RMHMO is a viable, sustainable health plan over the long term. In addition, UHS has agreed that:

- RMHMO will form an advisory board made up of local community representatives, such as management, physicians, consumers and plan sponsors to assist RMHMO with model business development, relationship management, social responsibility and other matters important to serving the communities that RMHMO has serviced historically;
- UHS will, or will cause RMHMO to, continue to support the community in Western Colorado for three (3) years at RMHMO's current level of community benefit support up to \$500,000 per year, including Quality Health Network, Hope West, Hilltop Community Resource, Marillac Clinic, Strive and the Colorado Mesa University Nursing Program; and
- UHS will cause RMHMO to maintain its Medicare Cost Contract for at least three (3) years in geographic areas on the Western Slope of Colorado and those Front Range Colorado geographic areas in which the Applicants' affiliates do not offer Medicare health plans; provided that there are no material changes to policies, rates or operational requirements of Medicare Cost plans that would adversely impact the financial performance of the Medicare Cost Contract.

The Applicants have no current plans or proposals to declare an extraordinary dividend, to liquidate the Insurance Entities, to sell any of the Insurance Entities' assets (except for investment transactions and minor asset dispositions in the ordinary course of business), to merge the Insurance Entities with any person or persons, or to make any other material change in any of the Insurance Entities' business operations, management or corporate structure, in each case except as set forth below. Following consummation of the acquisition, the Applicants intend to closely evaluate the operations and businesses of the Insurance Entities to determine how best to optimize the value of the operations and business expertise of the Insurance Entities.

Immediately following the consummation of the acquisition, all of the members of RMHMO's board of directors and certain executive officers of the Insurance Entities will be replaced and the persons listed in Exhibit 7 (or such other persons identified in a supplemental filing) will serve as the Insurance Entities' directors and executive officers. The directors and officers of the Insurance Entities that are being replaced and that are employees will likely remain employees in the combined organization and active in its operations. Following consummation of the acquisition, the Applicants intend to retain all or nearly all of the key personnel from the Insurance Entities to facilitate continuity of operations. The Applicants will seek to enter into employment agreements with certain key employees of RMHMO or its subsidiaries prior to closing. To the extent not already on file with the CDI, biographical affidavits for the expected executive officers and directors of the Insurance Entities are set forth in Exhibit 8. The biographical affidavits for the expected officers and directors of the Insurance Entities provided in Exhibit 8 contain confidential information. They are marked "CONFIDENTIAL" and are being separately filed in a sealed envelope marked "Confidential." The Applicants request that (i) the biographical affidavits be afforded confidential treatment in order to avoid unwarranted invasions of personal privacy, (ii) the Applicants be notified in advance of any proposed disclosure of the biographical affidavits by the CDI, and (iii) the Applicants be given a reasonable opportunity to seek a protective order or take other action to prevent or limit any such disclosure.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

Subject to the terms of the Agreement, following the effectiveness of the Conversion and conditioned upon attaining necessary regulatory approvals, UHS will acquire all of the issued and outstanding shares of capital stock of RMHMO. UHS will, by virtue of owning all of the issued and outstanding capital stock of RMHMO, own 100% of the membership interest in RMHCO.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

None of the Applicants, their affiliates or any person referenced in Item 3 owns any interest in (or has a right to acquire) the membership interests or voting securities of the Insurance Entities, except as set forth in the Agreement.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Except as provided in the Agreement, there are no contracts, arrangements or understandings with respect to any membership interest or voting security of the Insurance Entities in which the Applicants, their affiliates or any person listed in Item 3 is involved, including any transfer of any securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

There have been no acquisitions of any membership interest or voting securities of the Insurance Entities by the Applicants, their affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this Statement.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

There have been no recommendations to acquire any membership interest or voting security of the Insurance Entities made during the 12 calendar months preceding the filing of this Statement by the Applicants, their affiliates or any person listed in Item 3, or by any other person based on interviews or at the suggestion of the Applicants, their affiliates or any person listed in Item 3.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

There have been no agreements, contracts or understandings made with any broker-dealer as to solicitation of membership interests or voting securities of the Insurance Entities for tender.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

Stock Purchase Agreement dated July 22, 2016 among UHS, Seller, and RMHMO, along with exhibits (Exhibit C filed separately with the CDI in a sealed envelope marked "Confidential," as noted in the Vaughn Index filed with this Statement)	<u>Exhibit 1</u>
Pre-Acquisition organizational chart for the Insurance Entities and their affiliates	<u>Exhibit 2</u>
Pre-Acquisition simplified organizational chart for the Applicants and affiliates	<u>Exhibit 3</u>
Pro forma post-Acquisition simplified organizational chart for the Applicants and affiliates	<u>Exhibit 4</u>
List of directors and executive officers of UHG and UHS	<u>Exhibit 5</u>
Biographical Affidavits for the directors and executive officers of UHG and UHS (filed separately with the CDI in a sealed envelope marked "Confidential," as noted in the Vaughn Index filed with this Statement)	<u>Exhibit 6</u> <i>(to be filed once available)</i>

List of persons expected to serve as the Insurance Entities' directors and executive officers	<u>Exhibit 7</u>
Biographical Affidavits for the persons expected to serve as the Insurance Entities' directors and executive officers (filed separately with the CDI in a sealed envelope marked "Confidential," as noted in the Vaughn Index filed with this Statement)	<u>Exhibit 8</u> <i>(to be filed once available)</i>
2015 Annual Report of UHG	<u>Exhibit 9-A</u>
2014 Annual Report of UHG	<u>Exhibit 9-B</u>
Annual Report on Form 10-K of UHG for the year ended December 31, 2015, filed with the Securities and Exchange Commission (includes audited financial statements for 2015 and 2014)	<u>Exhibit 10-A</u>
Annual Report on Form 10-K of UHG for the year ended December 31, 2014, filed with the Securities and Exchange Commission (includes audited financial statements for 2014 and 2013)	<u>Exhibit 10-B</u>
Annual Report on Form 10-K of UHG for the year ended December 31, 2013, filed with the Securities and Exchange Commission (includes audited financial statements for 2013 and 2012)	<u>Exhibit 10-C</u>
Annual Report on Form 10-K of UHG for the year ended December 31, 2012, filed with the Securities and Exchange Commission (includes audited financial statements for 2012 and 2011)	<u>Exhibit 10-D</u>
Quarterly Report on Form 10-Q of UHG for the period ended March 31, 2016, filed with the Securities and Exchange Commission	<u>Exhibit 11-A</u>
Quarterly Report on Form 10-Q of UHG for the period ended June 30, 2016, filed with the Securities and Exchange Commission	<u>Exhibit 11-B</u> <i>(to be filed once available)</i>
Pro forma financial projections for the Insurance Entities for the years 2016, 2017, 2018 and 2019 (filed separately with the CDI in a sealed envelope marked "Confidential," as noted in the Vaughn Index filed with this Statement)	<u>Exhibit 12</u>
Form of Employment Agreement	<u>Exhibit 13</u>

The financial projections for the Insurance Entities provided in Exhibit 12 are confidential information and they are being separately filed in a sealed envelope marked "Confidential." The Applicants request that (i) the financial projections be afforded confidential treatment because their public disclosure would cause substantial harm to the Applicants by allowing competitors to obtain nonpublic information about the Applicants' financial analysis underlying this acquisition, (ii) the Applicants be notified in advance of any proposed disclosure by the CDI, and (iii) the Applicants be given a reasonable opportunity to seek a protective order or take other action to prevent or limit any such disclosure.

As stated in Item 5, Applicants will seek to enter into employment agreements with certain key employees of RMHMO or its subsidiaries prior to closing. The agreements will be substantially in the form of Exhibit 13 attached hereto.

ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

The Applicants agree to provide, to the best of their knowledge and belief, the information required by Form F within fifteen days after the end of the month in which the acquisition of control occurs. The Applicants and all subsidiaries within their control in the insurance holding company system shall provide information to the Director upon request necessary to evaluate enterprise risk.

[Remainder of page intentionally left blank; signature page to follow.]

ITEM 14. SIGNATURE AND CERTIFICATION

SIGNATURE

Pursuant to the requirements of Section 10-3-804, C.R.S., UnitedHealth Group Incorporated has caused this application to be duly signed on its behalf in the City of Minnetonka and State of Minnesota on the 2nd day of August, 2016.

THIS CORPORATION HAS
NO SEAL

UnitedHealth Group Incorporated

By: 

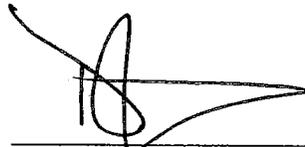
David S. Wichmann, President

Attest:


Richard J. Mattera, Assistant Secretary

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached application dated August 3, 2016, for and on behalf of UnitedHealth Group Incorporated; that he is the President of such company and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.



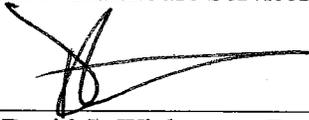
David S. Wichmann, President

SIGNATURE

Pursuant to the requirements of Section 10-3-804, C.R.S., United HealthCare Services, Inc. has caused this application to be duly signed on its behalf in the City of Minnetonka and State of Minnesota on the 2nd day of August, 2016.

THIS CORPORATION HAS
NO SEAL

United HealthCare Services, Inc.

By: 

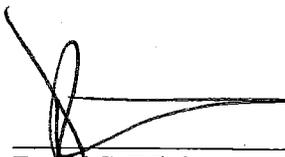
David S. Wichmann, Executive Vice President

Attest:


Heather A. Lang Jacobsen, Assistant Secretary

CERTIFICATION

The undersigned deposes and says that he has duly executed the attached application dated August 3, 2016, for and on behalf of United HealthCare Services, Inc.; that he is the Executive Vice President of such company and that he is authorized to execute and file such instrument. Deponent further says that he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.


David S. Wichmann, Executive Vice
President