STATE OF CONNECTICUT

INSURANCE DEPARTMENT

ORDER ADOPTING REPORT OF EXAMINATION

I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, having fully considered and reviewed the Examination Report (the "Report") of Oxford Health Plans (CT), Inc. ("the Company") as of December 31, 2016, do hereby adopt the findings and recommendations contained therein based on the following findings and conclusions.

TO WIT:

1. I, Katharine L. Wade, Insurance Commissioner of the State of Connecticut, and as such is charged with the duty of administering and enforcing the provisions of Title 38a of the Connecticut General Statutes ("C.G.S.").

2. The Company is a domestic insurer authorized to transact the business of insurance in the State of Connecticut.

3. On May 14, 2018, the verified Report of the Company was filed with the Connecticut Insurance Department (the "Department").

4. In accordance with C.G.S. §38a-14(e)(3), the Company was afforded a period of thirty (30) days within which to submit to the Department a written submission or rebuttal with respect to any matters contained in the Report.

5. On May 18, 2018, the Company filed a written submission indicating that they were in agreement with all of the recommendations contained in the Report. A copy of the Report is attached hereto and incorporated herein as Exhibit A.

NOW, THEREFORE, it is ordered as follows:

1. That the Report of the Company hereby is adopted as filed with the Department.

2. That the Company shall comply with the recommendations set forth in the Report, and that failure by the Company to so comply shall result in sanctions or administrative action as provided by Title 38a of the C.G.S.

3. Section 38a-14(e)(4)(A) of the CGS requires that:

   "The secretary of the Board of Directors or similar governing body of the entity shall provide a copy of the report or summary to each director and shall certify to the Commissioner, in writing, that a copy of the report or summary has been provided to each director. "

   Please address the certification to the Commissioner, but send said certification to the care/attention of Mark Murphy, Supervising Examiner, of the Financial Regulation Division.

4. Section 38a-14(e)(4)(B) of the CGS requires that:

   "Not later than one hundred twenty days after receiving the report or summary. the chief executive officer or the chief financial officer of the entity examined shall present the report of summary to the entity's Board of Directors or similar governing body at a regular or special meeting. "

   This will be verified by the Insurance Department either through analysis or examination follow-up.

Dated at Hartford, Connecticut, this 24th day of May, 2018.

Katharine L. Wade
Insurance Commissioner

EXHIBIT A

EXAMINATION REPORT

OF THE

OXFORD HEALTH PLANS (CT), INC.
(NAIC # 96798)

AS OF

DECEMBER 31, 2016

BY THE CONNECTICUT INSURANCE DEPARTMENT

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May 9, 2018

The Honorable Katharine L. Wade
Insurance Commissioner
State of Connecticut Insurance Department
153 Market Street, 6th Floor
Hartford, Connecticut 06103

Dear Commissioner:

In compliance with your instructions and pursuant to the requirements of Section 38a-14 of the Connecticut General Statutes (CGS), the undersigned has made an examination of the conditions and affairs of

OXFORD HEALTH PLANS (CT), INC.

(hereinafter referred to as the Company or OHPCT), a corporation with capital stock, incorporated under the laws of the State of Connecticut and having its statutory home office and main administrative office located at 4 Research Drive, Shelton, Connecticut. The report of such examination is submitted herewith.

SCOPE OF EXAMINATION

The previous examination of the Company was conducted by the Financial Regulation Division of the Connecticut Insurance Department (Department) as of December 31, 2011. The current examination, which covers the period from January 1, 2012 to December 31, 2016, was conducted at UnitedHealthcare Insurance Company (UHIC), the Company's affiliate located in Hartford, Connecticut. A concurrent examination of UHIC was performed.

The current examination was conducted as part of a multi-state examination of the UnitedHealth Group Incorporated (UHG) holding company, in which the Department served as lead state and coordinated the simultaneous examination of twenty-nine (29) regulated entities domiciled in seventeen (17) states, including Connecticut and its regulated entities (the coordinated examination). The coordinated examination not only provided information on each insurer individually but also provided a structure for regulators to understand and evaluate risks of the holding company group as a whole.

As part of the examination planning procedures, the Department reviewed the following materials from 2012 through 2016:

- statutory audit reports completed by the Company's independent certified public accountant, Deloitte & Touche, LLP (D&T);
- Board of Director (Board) and other committee minutes (through the latest 2017 minutes);
- Management's Discussion and Analysis;
- Statements of Actuarial Opinion;
- reports of the Company's Internal Audit and Advisory Services Department (IAAS);
- documentation supporting Section 404 of the Sarbanes Oxley Act of 2002 (SOX);
- 10-K reports filed with the Securities and Exchange Commission; and
- Annual Statements filed with the Department.

A comprehensive review was made of the financial analysis files and documents submitted to the Financial Analysis Unit of the Department and reports from the National Association of Insurance Commissioners (NAIC) database, all of which indicated no material concerns with respect to financial condition or regulatory compliance.

Work papers prepared by the Company's independent certified public accountants D&T were reviewed and relied upon to the extent deemed appropriate.

Work papers prepared by the Company's IAAS, including internal audit work contracted with Ernst & Young LLP, were reviewed and relied upon to the extent deemed appropriate.

Lewis & Ellis Actuaries & Consultants (L&E) was engaged by the Department to assist in the review of the Company's reserving, pricing/underwriting and reinsurance risks for the coordinated examination.

Risk & Regulatory Consulting, LLC (RRC) was engaged by the Department to assist in the review of the Company's Information Technology (IT) General Controls (ITGCs) for the coordinated examination.

The examination was conducted on a full scope, comprehensive basis in accordance with the procedures outlined in the NAIC Financial Condition Examiners Handbook (the Handbook). The Handbook requires that we plan and perform the examination to evaluate the financial condition and identify prospective risks of the Company by obtaining information about the Company, including corporate governance, identifying inherent risks within the Company, and evaluating system controls and procedures used to mitigate those risks. An examination also includes assessing the principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation, management compliance with the NAIC Accounting Practices & Procedures Manual (Manual) and the NAIC Health Annual Statement Instructions.

All accounts and activities of the Company were considered in accordance with the risk-focused examination process.

Comments in this report are generally limited to exceptions noted or to items considered to be of a material nature.

Failure of items in this report to add to totals or for totals to agree with captioned amounts is due to rounding.

HISTORY

The Company is a wholly owned subsidiary of Oxford Health Plans, LLC (Oxford LLC). Oxford LLC is a wholly owned subsidiary of UHG. UHG is a publically held company trading on the New York Stock Exchange.

The Company was incorporated under the laws of Connecticut on April 18, 1985, to provide comprehensive health care services to its members on a prepaid basis. The Company, an Independent Professional Association model Health Maintenance Organization (HMO), was granted authority to operate as a Connecticut HMO by the Connecticut Department of Health. On February 2, 1995, the Company amended and restated its Articles of Incorporation to reorganize as a health care center, pursuant to Sections 38a-175 through 38a-192 of the CGS.

The Company became part of UHG on July 29, 2004, pursuant to the acquisition by UHG of Oxford LLC, formerly Oxford Health Plans, Inc., a Delaware corporation and sole shareholder of the Company.

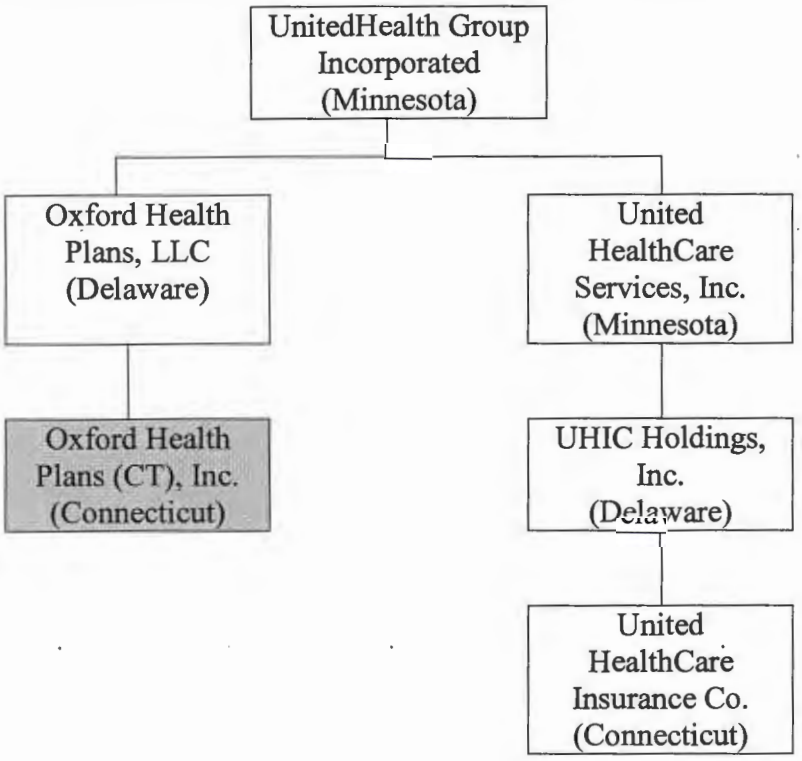
Effective December 31, 2013, Health Net of Connecticut Inc. (HNNT CT), a Connecticut domiciled HMO, was merged into the Company under a statutory merger. The Company remained as the surviving entity. The transaction was approved by both the Department and Connecticut State Treasurer, Division of Revenue.

Effective April 5, 2016, the Articles of Incorporation were amended and restated to expand the service area to New Jersey.

Effective July 1, 2016, AmeriChoice of Connecticut, Inc. (AMC CT), an affiliated Connecticut domiciled HMO, was merged into the Company under a statutory merger. The Company remains as the surviving entity. The transaction was approved by both the Department and Connecticut Secretary of State.

ORGANIZATIONAL CHART

The following is a portion of the Company's organizational chart as of December 31, 2016:



MANAGEMENT AND CONTROL

The bylaws state that all meetings of the stockholders shall be held on such date and at such time as shall be designated from time to time by the Board. If an annual meeting is held, then at such meeting of the stockholders shall elect a Board and transact such business as may properly be brought before the meeting. Special meetings of the stockholders, called by the Board, the Chief Executive Officer, or the stockholders as permitted under the Connecticut Business Corporation Act (Act), may be held at any time and for any purpose or purposes, unless otherwise prescribed by statute.

The number of directors of the Company shall be determined from time to time by the Board but in no case shall the number of directors be less than one.

At December 31, 2016, directors of the Company were as follows:

Name	Title and Principal Business Affiliation
Stephen John Farrell	UHC* – E&I Northeast Health Plan Chief Executive Officer
William John Golden	UHC* – E&I Regional Chief Executive

Sandra Denise Bruce Nichols, M.D.	Officer Shared Services Regional Chief Medical Officer, UHG
Randall Harrison Weinstock	UHC* – VP E&I Finance

*UHC – UnitedHealthcare (Health Benefits Segment)

The Company shall have such officers as the Board, the Chief Executive Officer, if any, or the president, if any, from time to time may elect; provided, however, that the Chief Executive Officer and the president shall be elected by the Board.

Each officer shall hold office until his or her successor has been elected and qualified, unless a different term is specified at the time such officer is elected, or until his or her earlier death, resignation or removal.

At December 31, 2016, the officers of the Company were as follows:

Name	Title
William John Golden	Chair
Stephen John Farrell	President
Timothy Callahan Archer	Chief Financial Officer
Carmel Colica	Secretary
Robert Worth Oberrender	Treasurer
Thomas Joseph McGuire	General Counsel
Heather Anastasia Lang Jacobsen	Assistant Secretary
Nyle Brent Cottington	Vice President
Sanford Paul Cohen, M.D.	Chief Medical Officer

RELATED PARTY TRANSACTIONS

The Company is a party to numerous related party transaction agreements. The most significant agreements are as follows:

Management Services Agreement

The Company is a party to a Management Services Agreement with United HealthCare Services, Inc. (UHS). Services provided by UHS include management and general administration services and operations services. UHS minimally provides, accounting, investment legal, actuarial, underwriting, and claim adjudication.

This agreement was amended on February 1, 2017, and was approved by the Department. This amendment updated the methodology for calculating management fees to utilize more current information. With permission from the Department the updated methodology was utilized in 2016.

Tax Allocation Agreement
The Company files a consolidated federal tax return with UHG and members of the affiliated group based on a written tax sharing agreement. The federal income tax is allocated to each of the companies in the consolidated group in a manner that approximates each company's liability on a separate tax company basis.

Behavioral Health Agreement
The Company contracts with an affiliate, United Behavioral Health to provide mental health and substance abuse services for its enrollees.

Pharmacy Benefit Management Agreement
The Company contracts with an affiliate, Optum Rx, to provide administrative services related to pharmacy management and pharmacy claims processing for its enrollees.

Claim Analytics, Overpayment Recover and Fraud, Waste and Abuse Agreement
The Company contracts with an affiliate, Optum Insight Inc., to provide claim analytics, recovery of medical expense overpayments, retroactive fraud, waste and abuse, subrogation and premium audit services.

Revolving Credit Agreement
The Company holds a $40,000,000 subordinated revolving credit agreement with UHG at an interest rate of the London InterBank Offered Rate plus a margin of 0.50%. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party.

TERRITORY AND PLAN OF OPERATION

Plan of Operations
The Company, licensed in the state of Connecticut, offers comprehensive managed care benefits through participating network physicians, hospitals and other providers and emphasizes preventative and primary medical care through its primary care physicians. The Company also markets point of service plans, Medicare, Medicare Advantage, and Medicare Part-D (Part D) prescription drug coverage plans in Connecticut. The Medicare Advantage and Part D coverage is offered under a contract with the Centers for Medicare and Medicaid Services. On April 18, 2016, the Corporation received approval from the New Jersey Department of Banking and Insurance and was licensed to transact Medicare business in New Jersey.

Marketing and Agency System
The Company's managed health care insurance products and services are distributed predominately through a captive sales force as well as independent insurance agents, brokers, and consultants.

REINSURANCE

UHIC Insolvency-Only Reinsurance Agreement

The Company has an insolvency-only reinsurance agreement with an affiliated company, UHIC, which provides insolvency protection for its enrollees.

Unimerica Reinsurance Agreement

Effective July 1, 2013, the Company entered into a reinsurance agreement with an affiliated entity, Unimerica Insurance Corporation, to cede obligations relating to; chiropractic and physical therapy coverage, transplant coverage, infertility treatment coverage, and mental health and substance use disorder coverage.

Connecticut Small Employer Health Reinsurance Pool (CSEHRP)

The Company is a participant in CSEHRP, incorporated under Section 38a-572 of the CGS. Under this section, each insurer issuing health insurance in Connecticut on and after July 1, 1990, shall be members of this pool. The purposes of the pool include assuring the availability of appropriate health care coverage to Connecticut residents on an affordable basis, assisting in creating the means to assure health care coverage for residents on an equitable financing basis and with effective cost controls, facilitating the provision of lower cost health care coverage for uninsured small employers, and providing a reinsurance mechanism to facilitate the provision of small employer coverage. The Company retains $5,000 on each individual cession.

INFORMATION TECHNOLOGY CONTROLS

RRC performed a risk-based assessment and review of the Company's ITGCs in accordance with NAIC requirements as outlined in the Handbook. The guidance and direction used to perform the review of the Company's ITGCs was derived from Exhibit C Part 1 – Information Technology Planning Questionnaire (ITPQ) and Exhibit C Part 2 – Information Technology Work Program (collectively, Exhibit C). The Company's responses to the ITPQ were evaluated, and certain controls within the IT control environment were tested to assess whether the selected controls were designed effectively and were functioning properly.

RRC's objectives were to obtain reasonable assurance about whether:

- the Company has a process in place to effectively identify, mitigate and manage its IT risks.
- the Company's control structure policies and procedures were suitably designed to achieve the control objectives specified in the Exhibit C, and if those policies and procedures were complied with.
- the Company's policies and procedures were in place during the examination period.

The objectives above were achieved through a combination of reviewing the Company's policies and procedures, testing in key areas related to the Exhibit C, interviewing the Company's IT senior management, reviewing IT risk assessment processes and leveraging relevant risk assessment procedures performed by D&T and IAAS.

In accordance with the Handbook, specific areas of review included:

- IT governance and organization structure;
- strategic planning, systems architecture and project oversight;
- IT risk management;
- vendor management;
- development and maintenance of policies;
- physical and logical security;
- business continuity and disaster recovery planning;
- end user or business developed applications; and
- cybersecurity and incident response.

Based upon the risk-based assessment and review, the Company's ITGCs were determined to be effective.

MEDICAL LOSS RATIO

Within the "aggregate health policy reserves" liability, the Company reported $0, for its statutory medical loss ratio (MLR) rebate liability as of December 31, 2016. The Patient Protection and Affordable Care Act (ACA) requires insurers to spend a minimum percentage of premium dollars on medical services and activities designed to improve health care quality. The Department reviewed and tested the Company's processes and controls designed to mitigate specific risks associated with accuracy, payment and reporting of rebates. No significant solvency concerns were identified.

ACCOUNTS AND RECORDS

As a member of a holding company group, the Company utilizes common systems for recording its transactions. The current general ledger system is Oracle PeopleSoft, which maintains GAAP, statutory, and MLR data. The Company uses Eagle Wings filing software to produce its statutory Annual Statement.

OXFORD HEALTH PLANS (CT), INC.

FINANCIAL STATEMENTS

The following statements represent the Company's financial position, as filed by the Company as of December 31, 2016. No adjustments were made to surplus as a result of the examination.

ASSETS

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$114,117,575		$114,117,575
Cash	(3,103,150)		(3,103,150)
Cash equivalents	849,928		849,928
Short-term investments	59,261,240		59,261,240
Investment income due and accrued	1,024,765		1,024,765
Uncollected premiums and agents' balances in the course of collection	1,399,450	$457,652	941,798
Accrued retrospective premiums	19,553,044		19,553,044
Amounts recoverable from reinsurers	25,960		25,960
Amounts receivable relating to uninsured plans	1,451,122	65,078	1,386,044
Current federal and foreign income tax recoverable and interest thereon	6,704,353		6,704,353
Net deferred tax asset	3,015,281	610,236	2,405,045
Health care ($15,398,918) and other amounts receivable	18,616,234	3,217,316	15,398,918
Aggregate write-ins for other than invested assets	1,703,235	138,483	1,564,752
Total	$224,619,037	$4,488,765	$220,130,272

OXFORD HEALTH PLANS (CT), INC.

LIABILITIES, CAPITAL AND SURPLUS

LIABILITIES	Covered	Uncovered	Total
Claims unpaid	$61,632,401		$61,632,401
Accrued medical incentive pool and bonus amounts	8,918,689		8,918,689
Unpaid claims adjustment expenses	670,295		670,295
Aggregate health policy reserves; including the liability of $0 for medical loss ratio rebate per the Public Health Service Act	4,039,001		4,039,001
Aggregate health claim reserves	68,900		68,900
Premiums received in advance	1,551,168		1,551,168
General expenses due or accrued	5,778,213		5,778,213
Ceded reinsurance premiums payable	96,922		96,922
Remittances and items not allocated	15,038		15,038
Amounts due to parent, subsidiaries and affiliates	45,381,660		45,381,660
Liability for amounts held under uninsured plans	3,297,981		3,297,981
Aggregate write-ins for other liabilities	28,593		28,593
Total liabilities	$131,478,861		$131,478,861
CAPITAL AND SURPLUS	Covered	Uncovered	Total
Aggregate write-ins for special surplus funds	XXX		$0
Common capital stock	XXX		200
Gross paid in and contributed surplus	XXX		62,736,211
Unassigned funds (surplus)	XXX		25,915,000
Total capital and surplus	XXX		88,651,411
Total liabilities, capital and surplus	XXX		$220,130,272

OXFORD HEALTH PLANS (CT), INC.

STATEMENT OF REVENUE AND EXPENSES

STATEMENT OF REVENUE AND EXPENSES	Uncovered	Total
Member months	XXX	559,917
Net premium income	XXX	$477,743,980
Change in unearned premium reserves and reserve for rate credits	XXX	(1,603,764)
Total revenues	XXX	476,140,216
Hospital and Medical:		
Hospital/medical benefits		331,402,974
Other professional services		3,120,293
Emergency room and out-of-area		19,602,587
Prescription drugs		22,350,078
Incentive pool, withhold adjustments and bonus amounts		11,133,196
Subtotal		387,609,128
Less:		
Net reinsurance recoveries		712,291
Total hospital and medical		386,896,837
Claims adjustment expenses		21,896,107
General administrative expenses		53,861,092
Total underwriting deductions		462,654,036
Net underwriting gain or (loss)	XXX	13,486,180
Net investment income earned		2,505,462
Net realized capital gains/(losses) less capital gains tax of $251,032		537,628
Net investment gains or (losses)		3,043,090
Net gain or (loss) from agents' or premium balances charged off		(515,731)
Aggregate write-ins for other income or expenses		315
Net income or (loss), after capital gains tax and before all other federal income taxes		16,013,854
Federal and foreign income taxes incurred		7,769,613
Net income (loss)	XXX	$ 8,244,241

CAPITAL AND SURPLUS ACCOUNT	
Capital and surplus, December 31, prior year	$79,688,862
Net income	8,244,241
Change in net deferred income tax	(29,908)
Change in non-admitted assets	(281,694)
Aggregate write-ins for gains or (losses) in surplus	1,029,910
Net change in capital and surplus for the year	8,962,549
Capital and surplus, December 31, current year	$88,651,411

CLAIMS UNPAID	$61,632,401
UNPAID CLAIMS ADJUSTMENT EXPENSE	$670,295
AGGREGATE HEALTH POLICY RESERVES	$4,039,001

L&E assisted the Department in its risk-based coordinated examination actuarial review of reserving and pricing /underwriting over the Company's Employer and Individual (commercial) and Medicare and Retirement (Medicare) business segments. Information reviewed in conjunction with this review included the following:

- 2016 and prior Annual Statements;
- 2016 Statement of Actuarial Opinion and Actuarial Memorandum;
- IAAS SOX control testing related to the reserving and pricing/underwriting processes;
- D&T workpapers;
- interviews with Company's reserving and pricing/underwriting actuaries;
- management reports;
- rate filing or bid documentation; and
- actuarial reserving models.

Reserving

L&E reviewed the following risks related to reserving:

- the reasonableness of assumptions and methodologies used in the development and valuation of the Claims Unpaid Liability;
- the reasonableness of the assumptions and methodologies used in the development and valuation of the non-lag liabilities (Loss Adjustment Expense (LAE), Extension Of Benefits (EOB) and Margin); and
- the adequacy and appropriateness of the analysis performed by the Company to determine the necessity of the Premium Deficiency Reserves (PDR) and the resulting reported amount.

The work performed by L&E related to these risks consisted of the following:

- obtained and reviewed a sample of the claim reserving models;
- reviewed the retrospective reserve analysis for the Company;
- obtained and reviewed the monthly reserve reporting documentation prepared by the Company;
- reviewed the development of the margin, EOB factors and LAE factors;
- obtained and reviewed the PDR model, methodology, assumptions and verified sources; and
- obtained and reviewed any PDR model updates.

Pricing/Underwriting

L&E reviewed the following risks related to pricing/underwriting:

- the development of and adherence to the overall pricing strategy;

- the adequacy of the pricing methodology and guidelines; and
- the adequacy of the risk methods and assumptions utilized to estimate the risk adjustment

The work performed by L&E related to these risks consisted of the following:

- obtained and reviewed the Company's various pricing strategies, including any reports in place to monitor results;
- reviewed the overall rating and bid process;
- obtained and reviewed a sample of ratings and bids to ensure appropriate factors were considered;
- obtained and reviewed D&T workpapers related to the methodology and accuracy of the risk adjustment estimation;
- reviewed a comparison of the final 2016 reported balances to final Center for Medicare & Medicaid Services calculated amounts (ACA Risk Adjustment); and
- reviewed settlements for prior years to verify accuracy of reported amounts (Medicare Risk Adjustment).

Conclusion

Based upon risk-based coordinated examination actuarial review, no material findings were noted which affected the Company's reserving pricing/underwriting risk.

AGGREGATGE WRITE-INS FOR SPECIAL SURPLUS FUNDS $0

The following exhibit reflects the balance of this account during the period under review:

2016	$0
2015	$8,814,489
2014	$9,638,091
2013	$0
2012	$0

Beginning January 1, 2014, Statement of Statutory Accounting Principles No. 106, ACA Section 9010 Assessment, of the Manual requires: (1) that the health insurer fee be recognized in full on January 1 of the fee year of the calendar year in which the assessment must be paid to the federal government; and (2) that in each data year preceding a fee year, a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to the captioned account an amount equal to its estimated subsequent fee year assessment. There was no impact to total capital and surplus. Annually, this fees is reversed in full on January 1 of the fee year beginning with fee years starting on January 1, 2015. During 2017, there was a one year moratorium on the health insurer fee and as such no balance as of December 31, 2016.

COMMON CAPITAL STOCK $200

As of December 31, 2016, the Company reported 20 shares authorized, issued and outstanding of $10 par value common stock.

GROSS PAID IN AND CONTRIBUTED SURPLUS $62,736,211

The following exhibit reflects the balance of this account during the period under review:

2016	$62,736,211
2015	$58,427,547
2014	$77,514,334
2013	$77,514,334
2012	$77,514,334

Fluctuations during the examination period related to statutory mergers and dividend payments.

UNASSIGNED FUNDS (SURPLUS) $25,915,000

The following exhibit reflects the balance of this account during the period under review:

2016	$25,915,000
2015	$8,846,196
2014	$11,370,635
2013	$38,729,145
2012	$26,350,065

During the examination period changes to surplus were primarily related to dividend payments and net income.

SUBSEQUENT EVENTS

Effective January 1, 2017, an affiliate, Oxford Health Plans (NJ), Inc. novated a CMS Medicare Advantage contract to the Company. The Medicare revenue associated with this novation represented 62% of total direct premium as of December 31, 2017. There was no transfer of assets or surplus as a result of the novation.

On February 14, 2017, the Department of Justice (DOJ) announced its decision to pursue certain claims within a lawsuit initially asserted against the Company and filed under seal by a whistleblower in 2011. The whistleblower complaint, which was unsealed on February 15, 2017, alleges that the Company, along with a number of other Medicare Advantage plans, made improper risk adjustment submissions and violated the False Claims Act. On March 24, 2017, the DOJ intervened in a separate lawsuit initially asserted against the Company and filed by a whistleblower in 2009 which concerned risk adjustment submissions by Medicare Advantage plans. On October 5, 2017, in one of the cases, the district court judge dismissed certain of the DOJ's claims with prejudice and dismissed all of the DOJ's remaining claims with leave to file prejudice of the case. The other case is now pending in the U.S. District Court for the Central District of California. The Company indicates that it cannot reasonably estimate the outcome that may result from these matters given its current position.

On March 13, 2017, the Company declared an ordinary cash dividend of $8,800,000 to the sole shareholder, Oxford LLC. The dividend was paid March 24, 2017.

On August 16, 2017 the Board of UHG announced that David S. Wichmann, president of UHG, will succeed Stephen J. Hemsley as Chief Executive Officer and become a director of UHG, effective September 1, 2017. On the same date, Mr. Hemsley assumed the newly created role of Executive Chairman of the Board; current Board Chairman, Richard Burke, will become Lead Independent Director.

CONCLUSION

The results of this examination disclosed that as of December 31, 2016, the Company had admitted assets of $220,130,272, liabilities of $131,478,861, and capital and surplus of $88,651,411. During the period under examination, admitted assets increased $4,084,366, liabilities increased $4,163,299, and capital and surplus decreased $78,933.

SIGNATURE

In addition to the undersigned, the following members of the Department participated in the examination: Mark Murphy, CFE; Michael Daniels, CFE; Edna Bosley; Keith Kleindienst, CFE; Kenneth Roulier, AFE, AES, CISA; Susan Pulaski, CPA; Ellen McCarthy, AFE; Grace Jiang, CFE; Tricia Davé, FSA, MAAA; and Dawn Cormier, CPA. The consulting firm of RRC and the actuarial firm of L&E also participated.

I, Michael Shanahan, CFE, solemnly swear that the foregoing report on examination is hereby represented to be a full and true statement of the condition and affairs of the subject insurer as of December 31, 2016, to the best of my information, knowledge and belief.

Respectfully submitted,

Michael Shanahan, CFE
Examiner-In-Charge
State of Connecticut
Insurance Department

State of Connecticut ss. Hartford

County of Hartford

Subscribed and sworn to before me, JOSEPH A. MEDINA
Notary Public on this 14th day of May, 2018.

Notary Public

JOSEPH A. MEDINA
NOTARY PUBLIC
MY COMMISSION EXPIRES Sept. 16, 20 20

My Commission Expires