United Healthcare Corporation Class Action Litigation

Frequently Asked Questions

Q 1: Overview

A: This class action lawsuit by health plan subscribers and beneficiaries against United Healthcare Corporation (n/k/a UnitedHealth Group) ("UHC") and its subsidiaries and affiliates has been settled for $350 million. The Settlement resolves lawsuits over the way UHC pays claims when members of UHC's health insurance plans use out-of-network medical providers for covered healthcare benefits. The action claims that UHC issued inadequate reimbursements to its members for Covered Services provided by Out-of-Network Providers by using the *Ingenix* databases and/or other protocols or methods, referred to as Seven Out-of-Network Reimbursement Policies. UHC denies the factual allegations and legal claims asserted by the Plaintiffs and denies any wrongdoing or liability.

A non-exhaustive list of subsidiaries and affiliates of UnitedHealth Group appears on page 1 of the Notice.

Q 2: What benefits does the Settlement provide?

A: The Settlement provides both monetary and non-monetary benefits to the members of the Class. The Settlement establishes a Cash Settlement Fund in the amount of $350 mil. Proceeds from the fund will be issued in accordance with the Plan of Allocation. The Plan of Allocation is a set of formulas that determine each claimant's proportionate share of the settlement proceeds. Also, as part of the Settlement, UHC will initiate certain business practices for the benefit of Class Members. These business practices are described in the Notice.

Q 3: Why did I receive this information when I was never a subscriber or out-of-network provider?

A: You received a Notice because your name and address was given to us by UHC as someone who was a UHC member, subscriber or beneficiary.

Q 4: Why did I receive more than one Notice?

A: You may have received more than one Notice, either because your name appeared more than once in the UHC records, or you may have had more than one member ID number if you changed your job during the Class Period, or if your employer changed health plans during the Class Period.

Q 5: I believe I am a Class Member, but I did not receive the Notice and Claim Form. How can I obtain a copy of these documents?

A: A copy of the Notice and Claim Form (in PDF format) is available on the Claims Administrator's website at www.berdonclaims.com. Alternatively, you may contact the Claims Administrator at the following toll-free number and request a copy: (800) 443-1073.

Q 6: What are my options?

A: Your options are described below.

Submit a Proof of Claim: This is the only way to share in the settlement proceeds, if you qualify.

Ask to be excluded: The only option that allows you to individually sue the Defendants over the claims resolved by this Settlement. You will not share in the settlement proceeds.

Object: If you wish, you may write to the Court about why you do not agree with the Settlement.

Go to a Hearing: If you wish, you or your counsel may attend the Final Settlement Hearing and ask to speak in Court about the Settlement.

Do nothing: If you do nothing, you will not share in the settlement proceeds. But unless you exclude yourself from the Settlement Class, you will be bound by any judgment or Court order

Q 7: What do I need to do in order to take part in this class action and receive a payment?

A: In order to be eligible for a payment from this class action, you must complete, sign and mail your Claim Form and supporting documentation (required for Group B, C and D claims) to the Claims Administrator, so that it is postmarked no later than October 5, 2010.

Q 8: How much money am I likely to receive from this class action?

A: The Settlement provides claimants in this class action with a Cash Settlement Fund of $350 mil. The Claims Administrator will determine your proportionate share of the Net Settlement Fund, based on the type of claim you file and other relevant information, and in accordance with the Plan of Allocation. The Plan of Allocation is a set of formulas that determine each claimant's proportionate share of the settlement proceeds. It is not possible to estimate your potential payment until all claims have been reviewed and evaluated.

Q 9: When can I expect to receive my payment?

A: UHC insures millions of people and we expect to receive a very large number of claims. All claims submitted to the Claims Administrator must be reviewed and evaluated. Those claimants who submitted incomplete or deficient claims will be given an opportunity to provide additional information and documentation in support of their claims. Once all claims are reviewed and evaluated, payments to eligible claimants are determined, and once a court order approving distribution is received, payments will be issued and other settlement benefits will go in effect. We expect that this process will take a substantial amount of time. Please be patient.

Q 10: If I missed the filing deadline, will my late claim be accepted?

A: We recommend that you file your late claim. The final decision as to whether your late claim be accepted or rejected rests with the Court.

Q 11: How can I exclude myself from this Settlement?

A: If you do not wish to be a Class Member and participate in the proposed Settlement, then you must submit a written request for exclusion to the Claims Administrator. Your request for exclusion must be postmarked no later than July 27, 2010. Please see the Notice for detailed instructions.

Q 12: I am a primary insured. Should my claim have information for the medical services and supplies I personally used, or those used by my family (myself and the dependents listed in my coverage)?

A: You need to submit one claim form for each Insurance Policy ID number. Your claim should include information for all family members covered by your policy.

Q 13: I have a number of healthcare services claims that UHC denied completely. Can I make a claim for such denied medical services?

A: No. This class action addresses only the Covered Out-of-Network healthcare benefits. If a Defendant determined that an out-of-network medical service was not covered (your Explanation of Benefits would state that the Allowed Amount equals $0), then it is not eligible in this case.

Q 14: The Notice says that I may request certain claims information. What do I need to do?

A: The Claims Administrator received (or will receive) certain claims information for the services provided between January 1, 2002 and May 28, 2010 (the complete data sets, including information through May 28, 2010, will be available in July 2010). You may request such information for your Group B, C and/or D claim and use it to complete your claim form. To make a request, please do the following: (i) print a copy of the Claims Information Request Authorization Form, which is available on this website; (ii) complete the form; and (iii) submit it to the Claims Administrator. The Claims Information Request Authorization Form also appears on page 15 of the claim form.

Q 15: I am a Provider and would like to know whether some of the patients that owe me money filed claims in this case. What do I need to do?

A: Providers may request information from the Claims Administrator whether Subscribers who owe them money for covered out-of-network medical services have filed claims in this case. To make a request, please do the following: (i) check the applicable box in the claim form; and (ii) list the names of your patients with their Insurance Policy ID Numbers. Such requests will be processed at the time distribution of the Net Settlement Fund is made.

Q 16: Some of the information on my record of medical services is either missing or wrong. How do I complete/correct it?

A: You should make your changes and corrections on the report you received from the Clams Administrator. All additional information should be provided on a separate chart. The chart templates for Group B, C and D claims are available on the Claims Administrator's website at www.berdonclaims.com. Please note that all changes and updates in connection with the services and supplies you used must be properly documented.

Q 17: The Notice says that I may submit a claim for medical services received through the Final Order and Judgment Date. What is that date?

A: The Final Order and Judgment Date is the date the Court finally approves the Settlement and signs the Final Order and Judgment. Group B, C and D claims extend from the date within the Class Period that you became a Settlement Class Subscriber or Provider until the Final Order and Judgment Date. The actual date, once known, will be posted on this website sometime after the Settlement Hearing, which will be held on September 13, 2010.

Q 18: Are all claims for the medical services I used that were submitted to UHC eligible in this case?

A: No. You can only base your claim on the services that meet the following criteria: (i) the medical service or supply was a Covered Out-of-Network healthcare benefit; (ii) it was received during the Class Period, and for Group B, C, and D claims through the Final Order and Judgment Date; and (iii) the Allowed Amount reimbursed to the Subscriber was greater than $0.

Q 19: What is a Group A claim?

A: Group A claim is a simplified type of claim where the claimant is required to provide only the number of years, during the period from 1994 through 2009, that he/she were a member of any Defendant's healthcare plan that included provisions for Covered Out-of-Network Services or Supplies. Group A claimants do not need to provide supporting documentation. A Subscriber who elects to make a Group A claim may not elect to be included in any other group.

Please see the Notice for details.

Q 20: What is a Group B claim?

A: If you received a bill from your Provider for the amount that was not paid by the insurer, and paid it in full, you may have a Group B claim. If you paid only a portion of that bill, you may have both, Group B and Group C claims. Your Group B claim, in that case, would be based on the paid portion of that bill.

Please see the Notice for details.

Q 21: What is a Group C claim?

A: If you received a bill from your Provider for the amount that was not paid by the insurer, and paid nothing, you may have a Group C claim. If you paid only a portion of that bill, you may have both, Group B and Group C claims. Your Group C, in that case, claim would be based on the unpaid portion of that bill.

Please see the Notice for details.

Q 22: What is a Group D claim?

A: If you are a Provider and issued a bill to your patient for the amount that was not paid by the insurer, and the patient failed to pay the bill in part or in full, you may have a Group D claim. Your Group D claim is based on the unpaid portion of that bill.

Q 23: I believe I have assigned my claims to my Out-of-Network Provider. How does it affect my claim in this class action?

A: If you are a Subscriber and assigned benefit payments to a Provider and the Provider submits a valid claim, payments from the Net Settlement Fund will be made to the Provider.

Q 24: What type of supporting documentation is deemed acceptable?

A: The documentation requirements will vary based on the type of claim you are planning to make.

For *each* out-of-pocket payment, provide *copies* of:

- cancelled check; **or**
- receipt for cash payments; **or**
- invoices from your Out-of-Network Provider(s) indicating your payment(s); **or**
- internal accounting records from your Out-of-Network Provider reflecting your payment(s); **and**
- Explanation of Benefits ("EOB") or other documentation demonstrating that your Provider(s) was/were Out-of-Network and rendered Covered Out-of-Network Services or Supplies. You only need to provide an EOB for Covered Out-of-Network Services and Supplies that did not appear on the report you received from the Claims Administrator.

For *each* unpaid Adjusted Bill, provide *copies* of:

- Adjusted Bill issued by your Out-of-Network Provider; **or**
- evidence from your Out-of-Network Provider's records that an Adjusted Bill was sent to you; **and**
- EOB or other documentation demonstrating that your Provider(s) was/were Out-of-Network and rendered Covered Out-of-Network Services or Supplies. You only need to provide an EOB for Covered Out-of-Network Services and Supplies that did not appear on the report you received from the Claims Administrator.

For *each* unpaid Adjusted Bill that was submitted to a collection agency or reported to a credit agency, provide a *copy* of:

- a written notice from a collection agency; **or**
- evidence of telephone contact with a collection agency (see page 13 of the claim form), **or**
- a printout of your credit report showing that debt to your Out-of-Network Provider was reported to a credit agency; **or**
- an agreement with your Out-of-Network Provider to enter into a payment plan with you.

Those Out-of-Network Providers filing Group D claims and seeking increased damages must present records for the services provided and documentation in support thereof. Please see Section 5(b) of the claim form for further details.

Please note that your supporting documentation must clearly identify the service in question and provide all required information, such as date of service, subscriber's name, provider's name, amounts billed or paid, and other relevant details. You should not send any originals to the Claims Administrator, as your documents will not be returned.

Q 25: I am preparing a Claim Form on behalf of another person. What additional information is required in this case?

A: Please be sure to include your contact information, should the Claims Administrator have questions about the claim. If you are signing the Claim Form, you must include evidence that you have the authority to do so.

Q 26: What do I need to do to file a simplified claim as a patient?

A: Subscribers have an option to file a simplified claim, which is Group A claim.

Complete Section 1. In Section 2 on page 11, check the box to indicate that you wish to make a Group A claim. State the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan, which provided coverage for Out-of-Network Services or Supplies. Any portion of a given year should be treated as a whole year (for example: 3 years and 4 months should be entered as 4 years). You should then proceed to Section 6 on page 15, where you sign and date your claim. Your completed claim form must be submitted to the Claims Administrator by first class mail, postmarked no later than October 5, 2010. The address appears on pages 8 and 9 of the claim form.

Members of the Class making a Group A claim are not required to provide supporting documentation in connection with their medical coverage.

Q 27: What do I need to do to file a Group B claim?

A: Subscribers who received Adjusted Bills from their Out-of-Network Providers may file their claims based on the Out-of-Pocket Amounts they paid.

Complete Section 1. In Section 3 on page 11, check the box to indicate that you wish to make a Group B claim, and the box to indicate that you did, in fact, receive an Adjusted Bill(s). In Section 3(a), state the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan, which provided coverage for Out-of-Network Services or Supplies. Any portion of a given year should be treated as a whole year (for example: 3 years and 4 months should be entered as 4 years).

Next, you need to provide information requested in Section 3(b). The chart on page 11 of the claim form may not be sufficient to enter your information. We recommend that you use the Group B chart template, which is available on our website at www.berdonclaims.com. Alternatively, if you requested a copy of the claims information provided by Defendants, you should enter your information on the report itself.

For each out-of-pocket payment to your Out-of-Network Providers, that is a part of you Group B claim, you must supply supporting documentation. Various types of supporting documentation deemed acceptable for this purpose are described on page 12 of the claim form and in this document under "*What type of supporting documentation is deemed acceptable?*"

You should then proceed to Section 6 on page 15, where you sign and date your claim. Your completed claim form must be submitted to the Claims Administrator by first class mail, postmarked no later than October 5, 2010. The address appears on pages 8 and 9 of the claim form.

Q 28: What do I need to do to file a Group C claim?

A: Subscribers who received Adjusted Bills from their Out-of-Network Providers may file their claims based on the unpaid portions of their Adjusted Bills.

Complete Section 1. In Section 4 on page 12, check the box to indicate that you wish to make a Group C claim, and the box to indicate that you did, in fact, receive an Adjusted Bill(s). In Section 4(a), state the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan, which provided coverage for Out-of-Network Services or Supplies. Any portion of a given year should be treated as a whole year (for example: 3 years and 4 months should be entered as 4 years).

Next, you need to provide information requested in Section 4(b). The chart on page 12 of the claim form may not be sufficient to enter your information. We recommend that you use the Group C chart template, which is available on our website at www.berdonclaims.com. Alternatively, if you requested a copy of the claims information provided by Defendants, you should enter your information on the report itself. Please refer to the section entitled *Options for Subscribers* on page 5 of the Notice to determine the appropriate Percent of Recognized Loss Claimed for each medical service received or medical supply purchased.

For each medical service received and medical supply purchased, that is a part of you Group C claim, you must supply supporting documentation. Various types of supporting documentation deemed acceptable for this purpose are described on pages 12-13 of the claim form and in this document under "*What type of supporting documentation is deemed acceptable?*"

You should then proceed to Section 6 on page 15, where you sign and date your claim. Your completed claim form must be submitted to the Claims Administrator by first class mail, postmarked no later than October 5, 2010. The address appears on pages 8 and 9 of the claim form.

Q 29: What do I need to do to file a claim that is both Group B and Group C?

A: If you paid a portion of the Adjusted Bill to your Out-of-Network Provider but did not pay the remainder, you may have both a Group B claim (for the amount you paid), and a Group C claim (for the amount you did not pay).

Complete Section 1. In Section 3 on page 11, check the box to indicate that you wish to make a Group B claim, and the box to indicate that you did, in fact, receive an Adjusted Bill(s). In Section 3(a), state the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan, which provided coverage for Out-of-Network Services or Supplies. Any portion of a given year should be treated as a whole year (for example: 3 years and 4 months should be entered as 4 years).

In Section 4 on page 12, check the box to indicate that you wish to make a Group C claim, and the box to indicate that you did, in fact, receive an Adjusted Bill(s). In Section 4(a), state the number of years (from

1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan, which provided coverage for Out-of-Network Services or Supplies.

Next, you need to provide information requested in Section 3(b) and Section 4(b). The charts on pages 11 and 12 of the claim form may not be sufficient to enter your information. We recommend that you use the *Group B & C* chart template, which is available on our website at www.berdonclaims.com. Alternatively, if you requested a copy of the claims information provided by Defendants, you should enter your information on the report itself. Please refer to the section entitled *Options for Subscribers* on page 5 of the Notice to determine the appropriate Percent of Recognized Loss Claimed for each medical service received or medical supply purchased.

For each medical service received and medical supply purchased, that is a part of you Group B and C claim, you must supply supporting documentation. Various types of supporting documentation deemed acceptable for this purpose are described on pages 12-13 of the claim form and in this document under "*What type of supporting documentation is deemed acceptable?*"

You should then proceed to Section 6 on page 15, where you sign and date your claim. Your completed claim form must be submitted to the Claims Administrator by first class mail, postmarked no later than October 5, 2010. The address appears on pages 8 and 9 of the claim form.

Q 30: What do I need to do to file a Group D claim?

A: Providers who received assignments from their patients may file their claims based on the Adjusted Bill Amounts the Subscribers did not pay them.

Complete Section 1. In Section 5 on page 13, check the box to indicate that you wish to make a Group D claim.

Request to receive claims information made available to the Claims Administrator by Defendants in connection with the Covered Out-of-Network Services or Supplies that were either received or provided from January 1, 2002 until May 28, 2010 (the complete data sets, including information through May 28, 2010, will be available in July 2010). You must authorize the Claims Administrator to send you this information (see page 8, paragraph 4 for instructions).

Review your report for accuracy. If you wish to file a simplified Group D claim, indicate your intention by checking the box in section 5(a) of the claim form.

If you wish to seek increased damages, please follow the instructions outlined in section 5(b) of the claim form. Use the report received from the Claims Administrator to provide requested information. Additional charts for Group D claims are available on the Claims Administrator's website at www.berdonclaims.com.

You should then proceed to Section 6 on page 15, where you sign and date your claim. Your completed form must be submitted to the Claims Administrator by first class mail, postmarked no later than October 5, 2010. The address appears on pages 8 and 9 of the claim form.

Q 31: What do I need to do to receive a copy of the claims information made available to the Claims Administrator by Defendants in connection with the Covered Out-of-Network Services of Supplies?

A: If you are a Subscriber or a Provider, you may request to receive claims information made available to the Claims Administrator by Defendants in connection with the Covered Out-of-Network Services or Supplies that were either received or provided from January 1, 2002 until May 28, 2010. You must authorize the Claims Administrator to send you this information. Please complete and sign the authorization form available on the Claims Administrator's website at www.berdonclaims.com, or you may use the authorization form on the bottom of page 15.

The "Notice Number" requested on the form can be found under the return address on the Notice mailed to you by the Claims Administrator. If you did not receive a mailed Notice from the Claims Administrator, enter "Not Available". Return your completed and signed form to the Claims Administrator by mail, fax or email (see page 9 for the Claims Administrator's contact information).

Q 32: I am a provider, but the subscriber did not assign their claim to me. May I still file a claim?

A: No. As a Provider, you are eligible to participate as a Group D claimant only if you (i) received an assignment from a Subscriber (for which you must provide documentation), (ii) submitted a claim to UHC for reimbursement of Covered Out-of-Network Services or Supplies, and (iii) have not transferred, sold or assigned the claim.

Q 33: I am a legal heir of a deceased Class Member. How can I make a claim based on the medical services received and/or medical supplies purchased by that Class Member?

A: Legal heirs or representatives of deceased Class Members must properly identify themselves in Section 1 on page 10 of the claim form. Additionally, they must include copies of death certificates or letters of estate administration to confirm their authority.