Report on

Market Conduct Examination

of

John Alden Life Insurance Company
Time Insurance Company
(PPO)
(Life & Health)

Milwaukee, Wisconsin

by Representatives of the

North Carolina Department of Insurance

as of

March 2, 2015

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Raleigh, North Carolina
March 2, 2015

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Honorable Commissioners:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of the Life and Health and the Preferred Provider Organization (PPO) lines of business of

John Alden Life Insurance Company
(NAIC # 65080)
Time Insurance Company
(NAIC # 69477)
NAIC Exam Tracking System Exam Number: NC170-M84
Milwaukee, Wisconsin

hereinafter generally referred to as the Companies, at the North Carolina Department of Insurance (Department) office located at 11 S. Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The North Carolina Department of Insurance conducted target examinations of the Life and Health line of business and the PPO line of business of John Alden Life Insurance Company and Time Insurance Company. The limited scope examination of the Life and Health line of business of the Companies commenced on September 20, 2010, and covered the period of January 1, 2007, through December 31, 2008, with analyses of certain operations of the Companies being conducted through March 2, 2015. The limited scope examination of the PPO line of business of the Companies commenced on September 20, 2010, and covered the period of January 1, 2007, through December 31, 2008, with analyses of certain operations of the Companies being conducted through March 2, 2015. This action was taken due to the Department's market surveillance activities. All comments made in this report reflect conditions observed during the period of the examinations.

The examinations were performed in accordance with the auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination was not comprehensive, but included a limited review of the Company's practices and procedures in the areas of general administration, provider relations and delivery system, utilization management, provider credentialing, claims practices, policyholder treatment, marketing, delegated oversight, and underwriting practices. The findings and conclusion contained within the report are based solely on the work performed and are referenced within the appropriate section of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance at or above the following levels: 0 percent for utilization review determinations, grievances (including quality of care), consumer complaints, sales and advertising, producers who were not appointed and/or licensed, and the use of forms and rates/rules that were neither filed with nor approved by the Department; 7 percent for claims

and the content of utilization management review notification letters; and 10 percent for all other areas reviewed.

EXECUTIVE SUMMARY

The market conduct examinations revealed concerns with Company procedures and practices in the following areas:

Claims Practices (PPO) – Denied Claims - Failure to provide an accurate Explanation of Benefits (EOB) to the claimant regarding member liability; failure to include all statutory requirements in denial notification for which additional information was requested; Claims Processing Standards - Failure to include statutorily compliant claims processing standards in written policies and procedures.

Claims Practices (Life and Health) – Individual Accident and Health Claims Denied, and Group Major Medical Claims Paid - Failure to pay, deny or notify an insured of the information needed to process the claim within 30 days of receipt.

Policyholder Treatment (PPO) – Failure to include all statutory requirements in the member grievance policies and procedures; Member Grievances - Failure to include all statutory requirements in the grievance acknowledgment letter and/or determination letter; failure to send an acknowledgment letter after receipt of a grievance; failure to provide the member with a 15-day notification prior to the grievance review meeting date; failure to send an acknowledgment letter within three business days of receipt of a grievance; failure to complete a grievance review within 30 days; and failure to send a grievance determination letter.

Marketing (PPO) – Failure to utilize marketing brochures which correctly outline the member's responsibility/liability regarding out-of-network emergency services.

Delegated Oversight (PPO) – Intermediary Organizations – Failure to receive prior approval from the Department after significantly modifying a form which was subsequently executed with two intermediaries; failure to receive approval from the Department prior to executing a pharmacy benefit manager agreement; and failure to submit timely the initial certification for two intermediaries; Intermediary Provider Contracts – Failure to demonstrate ongoing oversight of the provider contracts utilized by all four of its intermediaries; Network Availability and Accessibility Standards – Failure of one intermediary to sufficiently monitor its provider appointment wait time standards during the examination period; failure to provide documentation to demonstrate that one intermediary monitored its established hospital provider availability standards during the examination period; failure to provide a comprehensive explanation of the PPO benefit plan to all enrollees during the examination period; failure to provide a copy of the 2008 provider directory for two of the Companies' intermediaries; failure of one intermediary to include all statutory requirements in its 2007 provider directory; and failure to produce documentation to demonstrate one intermediary had monitored provider wait time standards during the examination period; Utilization Management – Failure to conduct proper oversight of the delegated entity's utilization management activities; and failure to require ongoing oversight in delegated utilization management policies and procedures regardless of the entity's URAC accreditation or any other accreditation status; Utilization Management Policies and Procedures – Failure to include all noncertification notice

requirements, including external review rights and/or availability of Managed Care Patient Assistance Program in the Company's utilization management policies and procedures; failure to communicate prospective and concurrent review determinations within three business days after receiving all necessary information; failure to have a medical doctor licensed to practice medicine in North Carolina evaluate the clinical appropriateness of prospective and retrospective review noncertifications; failure to maintain a copy of the noncertification in the prospective review file; failure to include the member's right to an external review in retrospective review noncertification notifications; and failure to send the retrospective review noncertification notification to the covered person and the covered person's provider; Appeals Records Review – Failure to send an acknowledgment letter within three business days of receipt of appeal requests; Provider Credentialing – Failure to demonstrate to the Department that the Companies had conducted required oversight of the credentialing functions delegated to three intermediaries; and failure to maintain quarterly provider updates from one intermediary.

Underwriting Practices (Life and Health) – Individual Accident and Health Issued, Declined, Individual Accident and Health Issued Substandard, and Individual Major Medical Issued – Applications signed and dated prior to the producer's appointment. Individual Accident and Health Issued Substandard and Individual Major Medical Declined – Failure to use an Adverse Underwriting Decision (AUD) notice that was filed and approved by the Department or files did not contain copies of an AUD notice.

Utilization Management (Life and Health) – Prospective Review – Failure to complete the review and communicate the decision to the provider within three business days; Retrospective Review – Failure to complete the review within 30 days after receiving all necessary information and failure to provide the notification of certification to the provider within one day as required by the Companies' policies and procedures.

Special Concerns (PPO) – Failure to process 1,516 out-of-network emergency or inpatient ancillary claims in accordance with statutory requirements, and failure to reprocess all 1,516 claims correctly after two separate requests by the Department.

Specific violations are noted in the appropriate section of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web Site www.ncdoi.com, by clicking "INSURANCE DIVISIONS" then "Legislative Services".

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Companies are directed to take immediate corrective action to demonstrate their ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute

acceptance of such violations. Examination report findings that do not reference specific insurance laws, regulations, or bulletins are presented to improve the Companies' practices and provide consumer protection.

GENERAL ADMINISTRATION (PPO)

The Companies' general administration activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. No adverse trends or unfair trade practices were observed in this section of the examination.

PROVIDER RELATIONS AND DELIVERY SYSTEM (PPO)

The Companies' provider relations and delivery system activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. The Companies delegate the provision of their provider network to MedCost, LLC, Private Healthcare Systems (now MultiPlan), and WellPath Select, Inc. Medco Health Solutions, Inc. serves as the pharmacy benefits manager. Please refer to the Delegated Oversight section of this report for discussion of the Companies' monitoring activities.

UTILIZATION MANAGEMENT (PPO)

The Companies' utilization management activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. The Companies delegate utilization management to WellPath Select, Inc. Please refer to the Delegated Oversight section of this report for discussion of the Companies' monitoring activities.

PROVIDER CREDENTIALING (PPO)

The Companies' provider credentialing policies and procedures were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. The Companies delegate provider credentialing to MedCost, LLC, Private Healthcare Systems (now MultiPlan), and WellPath Select, Inc. Please refer to the Delegated Oversight section of this report for discussion of the Companies' monitoring activities.

CLAIMS PRACTICES (PPO)

The Companies' claims practices were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Paid Claims Sample Review

The Companies provided a listing of 398,232 paid claim lines. One hundred paid claim lines were randomly selected for review. The review revealed that five claims (5.0 percent error ratio) were processed beyond 30 days from receipt. The Companies paid the applicable interest for these claims at the time of adjudication in accordance with the provisions of NCGS 58-3-225(e). These interest payments totaled $114.24.

The average service time to process a claim payment was 10 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	63	63.0
8 - 14	9	9.0
15 - 21	17	17.0
22 - 30	2	2.0
31 - 60*	2	2.0
Over 60*	7	7.0
Total	**100**	**100.0**

* Four of nine claims processed over 30 days were properly pended by the Companies as additional information was required for adjudication. Three of the nine claims were pended. However, processing of the three claims exceeded 30 days beyond receipt of requested additional information. Two claims exceeding the 30 day processing timeframe were not pended.

Denied Claims Sample Review

The Companies provided a listing of 152,024 denied claim lines. One hundred denied claim lines were randomly selected for review. The review revealed processing issues with 20 claims (20.0 percent error ratio). Therefore, the Companies did not adhere to the provisions of NCGS 58-3-225. The issues identified as a result of the review are detailed as follows:

- Nineteen claims (19.0 percent error ratio) contained lines denied due to provider coding issues for which the Explanation of Benefits (EOB) erroneously indicated member responsibility/liability. The EOBs lacked appropriate remark code narratives to reflect no responsibility on behalf of the member for these types of denials. It was noted that the Companies have subsequently initiated the steps necessary to apply these statements to EOBs when applicable.

- One claim (1.0 percent error ratio) was denied due to no receipt of requested additional information; however, the notice to the claimant did not state that the claim would be reopened if the information previously requested was submitted to the insurer within one year after the date of the denial notice closing the claim as required by the provisions of NCGS 58-3-225(d).

The average service time to process a claim denial was eight calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	63	63.0
8 - 14	18	18.0
15 - 21	7	7.0
22 - 30	5	5.0
31 - 60*	4	4.0
Over 60*	3	3.0
Total	**100**	**100.0**

*Seven claims processed over 30 days were properly pended by the Companies as additional information was required for adjudication.

Pended Claims Review

The Companies provided a listing of 29 pended claim lines. All pended claim lines were reviewed. This review revealed no issues as all claims were processed in accordance with the provisions of NCGS 58-3-225. No adverse trends or unfair trade practices were observed in this section of the examination.

Claims Processing Standards

The Companies' standards for claims processing accuracy and timeliness, as well as actual performance during the examination period, are outlined in the following chart:

Performance Measure*	2007		2008	
	Standard (%)	Actual (%)	Standard (%)	Actual (%)
Processing accuracy	97.0	99.2	97.0	99.2
Timeliness/General claims: 30 days	95.0	95.0	95.0	95.7
Timeliness/Specialty claims: 30 days	85.0	82.3	85.0	85.8

*Standards and results are not North Carolina specific

Although the Companies met the performance standard for timeliness/general claims on an annual basis, they failed to meet the standard during June 2007. In addition, the Companies failed to meet the performance standard for timeliness/specialty claims during nine separate months of 2007, causing the Companies to fail to meet this standard for that year. In 2008, the standard was met on an annual basis, but the Companies failed to meet the timeliness/specialty claims standard during four separate months of that year.

The Companies have established a standard for claims processing timeliness of 95 percent for general claims within 30 days, and 85 percent for specialty claims within 30 days. The standard does not meet the requirements of NCGS 58-3-225 (Prompt Pay Law), which state that within 30 days of receiving a claim, an insurer must perform an action, including sending either payment, notice of denial, or notice that the claim is officially pended, requiring additional information, or pended based on nonpayment of fees or premiums. Therefore, the Companies did not adhere to the provisions of NCGS 58-3-225, as their current standard does not comply with the statutory requirements.

Policy Rescissions Sample Review

The Companies have policies and procedures in place which specify guidelines for policy rescission and modification. The Companies provided a listing of 103 policy rescission files. Fifty files were randomly selected for review. The review revealed no issues as all rescissions were conducted in accordance with the Companies' policies and procedures. No adverse trends or unfair trade practices were observed in this section of the examination.

CLAIMS PRACTICES (LIFE AND HEALTH)

Individual Major Medical Claims Paid

The Companies provided a listing of 56,587 paid individual major medical claims files. One hundred files were randomly selected for review. No adverse trends or unfair trade practices were observed in this section of the examination.

The eight claims processed in excess of 30 days contained proper documentation that notification letters were sent timely.

The average service time to process a claim payment was 20 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	25	25.0
8 - 14	32	32.0
15 - 21	33	33.0
22 - 30	2	2.0
31 - 60	3	3.0
Over 60	5	5.0
Total	**100**	**100.0**

Individual Major Medical Claims Denied

The Companies provided a listing of 27,522 denied individual major medical claims files. One hundred files were randomly selected for review. No adverse trends or unfair trade practices were observed in this section of the examination.

The 24 claims processed in excess of 30 days contained proper documentation that notification letters were sent timely.

The average service time to process a claim denial was 32 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	45	45.0
8 - 14	23	23.0
15 - 21	6	6.0
22 - 30	2	2.0
31 - 60	7	7.0
Over 60	17	17.0
Total	**100**	**100.0**

Individual Accident and Health Claims Paid

The Companies provided a listing of 366 paid individual accident and health claims files. Fifty files were randomly selected for review.

Two claim files (4.0 percent error ratio) were not paid or were denied, or the insured was not notified of the information needed to process the claim within 30 days of receipt.

The additional six claims processed in excess of 30 days contained proper documentation that notification letters were sent timely.

The average service time to process a claim payment was 24 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	2.0
8 - 14	4	8.0
15 - 21	33	66.0
22 - 30	4	8.0
31 - 60	7	14.0
Over 60	1	2.0
Total	**50**	**100.0**

Individual Accident and Health Claims Denied

The Companies provided a listing of 580 denied individual accident and health claims files. Fifty files were randomly selected for review. No adverse trends or unfair trade practices were observed in this section of the examination.

The 14 claims processed in excess of 30 days contained proper documentation that notification letters were sent timely.

The average service time to process a claim denial was 30 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	4	8.0
8 - 14	22	44.0
15 - 21	7	14.0
22 - 30	3	6.0
31 - 60	2	4.0
Over 60	12	24.0
Total	**50**	**100.0**

Group Major Medical Claims Paid

The Companies provided a listing of 7,539 paid major medical claims files. One hundred files were randomly selected for review.

Ten claim files (10.0 percent error ratio) were not paid or were denied, or the insured was not notified of the information needed to process the claim within 30 days of receipt. The Companies did not adhere to the provisions of NCGS 58-3-225(b).

The Companies refused to pay interest on one claim because the provider of services was not located in North Carolina.

The average service time to process a claim payment was 17 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	37	37.0
8 - 14	18	18.0
15 - 21	24	24.0
22 - 30	11	11.0
31 - 60	4	4.0
Over 60	6	6.0
Total	**100**	**100.0**

Group Major Medical Claims Denied

The Companies provided a listing of 3,885 denied group major medical claims. Fifty files were randomly selected for review. No adverse trends or unfair trade practices were observed in this section of the examination.

The six claims processed in excess of 30 days contained proper documentation that notification letters were sent timely.

The average service time to process a claim denial was 13 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	26	52.0
8 - 14	9	18.0
15 - 21	7	14.0
22 - 30	2	4.0
31 - 60	6	12.0
Total	**50**	**100.0**

POLICYHOLDER TREATMENT (PPO)

The Companies' policyholder treatment activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The Companies' policy entitled "Grievance Process - North Carolina", effective throughout the examination period, failed to state specifically that its first level grievance acknowledgement letter must contain the name of the coordinator who would be responsible for handling the grievance. Therefore, the Companies did not adhere to the provisions of NCGS 58-50-62(e)(1). The Companies' second level acknowledgment letter did not state the 10 business day timeframe to make known to its members the name, address, and telephone number of the person designated to coordinate the grievance review. Additionally, the Companies' second level process did not outline all of the required second level procedures including: that the review panel shall hold and schedule a meeting within 45 days after receiving the second level grievance request; notifying the covered person in writing 15 days before the review meeting date; and advising the member that his/her right to a full review is not conditioned on his/her appearance at the hearing. Therefore, the Companies did not adhere to the provisions of NCGS 58-50-62(f)(1)(a) and (g)(1)(2) and(3).

In addition, the Companies' policy for their second level decision letter did not contain a statement that the decision is the insurer's final determination, nor did it provide information regarding the insured's right to request an external review. Therefore, the Companies did not adhere to the provisions of NCGS 58-50-62(h)(7).

Telephone Access

The Companies operate a call center which accepts member and provider telephone calls through a toll-free telephone line. The Client Services Department is available five days a week from 9:00 AM to 6:00 PM, Eastern Standard Time. After normal business hours and during holidays, a recorded message informs callers that the office is closed, and provides them with the hours of operation for the Client Services Department. Providers are given the option of using the self-service phone service to check member eligibility and/or the status of a claim.

The Client Services Department has established telephone service standards and monitors actual performance. Review of the telephone reports revealed that the Client Services Department did not meet the established 'average speed to answer' standard of 30 seconds in 2008. The 'average speed to answer' was exceeded by 13 seconds, resulting in an actual performance of 43 seconds.

Member Grievances

The Companies provided a listing of 253 member grievances. Fifty grievances were randomly selected for review to assess the Companies' timeliness and compliance with the provisions of NCGS 58-50-62 and their own policies and procedures.

- In 41 files (82.0 percent error ratio), the acknowledgement letter did not contain all of the required provisions such as the name, telephone number, and address of the coordinator; and information on how to submit additional written material.
- In 24 files (48.0 percent error ratio), the determination letter did not contain all of the required provisions such as including the notice of the availability of assistance from the Managed Care Patient Assistance Program, and including the telephone number and address of the Program.
- In 13 files (26.0 percent error ratio), the acknowledgement letter was not sent.
- In eight files (16.0 percent error ratio), the member did not receive a 15 day notification prior to the review meeting date.
- In four files (8.0 percent error ratio), the acknowledgement letter was not sent within three business days of receipt of the grievance.
- In four files (8.0 percent error ratio), the review was not completed within 30 days.

- In two files (4.0 percent error ratio), the determination letter was not sent.

The average service time to process a member grievance was 15 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	20	40.0
8 - 14	15	30.0
15 - 21	4	8.0
22 - 30	6	12.0
31 - 60	3	6.0
Over 60	2	4.0
Total	**50**	**100.0**

POLICYHOLDER TREATMENT (LIFE AND HEALTH)

Privacy of Financial and Health Information

The Companies provided privacy of financial and health information documentation for the examiners' review. The Companies exhibited policies and procedures in place that ensure that nonpublic personal financial or health information is not disclosed unless the customer or consumer has authorized the disclosure. The Companies were found to be in compliance with the provisions of NCGS 58-39-25, 58-39-26, and 58-39-27.

Consumer Complaints

The Companies provided a listing of 21 consumer complaints. All consumer complaints were reviewed. No adverse trends or unfair trade practices were observed in this section of the examination.

The following table displays the types of complaints received for each year of examination:

Type	2007	2008
Administrative Related	2	2
Agent Related	0	1
Claim Related	9	6
Underwriting Related	0	1
Total	**11**	**10**

The consumer complaint register was reviewed and found in compliance with provisions of Title 11 of the North Carolina Administrative Code, (NCAC), Chapter 19, Section 0103.

All complaints and inquiries, whether received by telephone or mail, were investigated and responded to with a letter of resolution. The average service time to respond to the complaints was eight calendar days. The Companies' response to each complaint was deemed to be appropriate to the circumstances. Two complaints were responded to in excess of seven calendar days; however, extensions were requested and granted for the complaints. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 – 7	19	88.3
15 – 21	2	11.7
Total	**21**	**100.0**

MARKETING (PPO)

The Companies' marketing brochures used during the examination period incorrectly stated that a covered person who seeks non-network emergency services is responsible for paying the provider any balance in excess of the negotiated rate. Therefore, the Companies did not adhere to the provisions of NCGS 58-3-190(d) and 58-3-200(d), which state that an insurer shall not impose cost-sharing strategies for emergency services that differ from the cost-sharing that would have been imposed if the physician or provider furnishing the services was a provider contracting with the insurer.

The marketing brochures which contain the noncompliant language include the following forms:

- TIC 29684.02.08
- TIC 29684.06.08
- TIC 29684.08.08
- TIC 29249.06.08
- TIC 29249.08.08
- TIC 29249.11.06

- TIC 29684.11.07
- TIC 29261.02.08
- TIC 29261.06.08
- TIC 29261.08.08
- TIC 29261.11.07
- TIC 29249.02.08
- TIC 29249.11.07
- JALIC 29249.02.08
- JALIC 29249.06.08
- JALIC 29249.08.08
- JALIC 29249.11.07

MARKETING (LIFE AND HEALTH)

Producer Licensing

The Companies provided a listing of 2,843 producer appointment files. Fifty were randomly selected for review.

One appointed producer file (2.0 percent error ratio) did not contain evidence that a due diligence background investigation had been completed on the prospective producer.

Two appointed producer files (4.0 percent error ratio) were incomplete as one file did not contain evidence of an electronic appointment form and one file referenced an imaged file that was corrupt and could not be reproduced.

The Companies provided a listing of 2,953 producer termination files. Fifty files were randomly selected for review.

One producer file (2.0 percent error ratio) was an invalid receipt because an appointment did not exist for the requested termination. The review was based on the remaining 49 terminated producer files.

Four producer files (8.2 percent error ratio) did not contain evidence that a notification of termination was sent to the producer.

One producer file (2.0 percent error ratio) did not contain evidence that the Department was notified of the producer's termination within 30 days after the effective date of the termination.

DELEGATED OVERSIGHT (PPO)

Intermediary Organizations

The Companies delegate the provision of their intermediary provider network to MedCost, LLC (MedCost), Private Healthcare Systems (PHCS [now MultiPlan]), and WellPath Select, Inc. (WellPath). Medco Health Solutions, Inc. (Medco) serves as the pharmacy benefits manager (PBM). The Companies did not adhere to the provisions of 11 NCAC 20.0202, 20.0203, and 20.0204 as they significantly modified an approved form, (PPO 25893 Rev. 3/00), which no longer meets all of the provisions of 11 NCAC 20.0202. The Companies subsequently executed the form as intermediary agreements with MedCost and WellPath without receiving prior approval from the Department. The Companies did not adhere to the provisions of 11 NCAC 20.0201 as they failed to receive approval from the Department prior to executing their PBM agreement with Medco.

The Companies did not adhere to the provisions of 11 NCAC 20.0204 and Bulletin 97-B-3 as they failed to submit timely the initial intermediary certifications for MedCost and Medco. The regulatory provisions require the Companies to submit the initial certification at the same time the Companies enter into a relationship with an intermediary.

Intermediary Provider Contracts

During the examination period, the Companies did not adhere to the provisions of 11 NCAC 20.0204 as they failed to demonstrate to the Department that they had conducted ongoing oversight of the provider contracts utilized by all four of their intermediaries to determine compliance with the provisions of 11 NCAC 20.0202 and 20.0204.

Network Availability and Accessibility Standards

The Companies did not adhere to the provisions of 11 NCAC 20.0304, as MedCost did not sufficiently monitor its provider appointment wait time standards during the examination period. The Companies stated that MedCost relied solely on member complaints and grievances

to determine if there were any concerns regarding appointment wait times, and none were reported during the examination period. This methodology does not yield results which demonstrate whether the established appointment wait time standards were met. MedCost has established the following provider availability standards:

- Primary care – 100 percent of total PCPs (Family Practice, Pediatrics, and Internal Medicine) - 100 percent coverage statewide and in each county. The panel is never closed.
- Specialists (certain specialties excluded*) – 70 percent coverage in each specialty.
- Podiatry, Physical Therapy, Mental Health Providers, and Optometry* - 30 percent coverage in each of these specialties
- Hospital – At least one primary care hospital per county (if available)

The Companies did not consistently meet their own established provider availability standards across all counties during the examination period. It was also noted that MedCost failed to provide a Coverage and Evaluation report for the third and fourth quarters of 2007, and therefore did not adhere to its own policies and procedures.

The Companies did not adhere to the provisions of 11 NCAC 20.0304, as they did not provide documentation to demonstrate that MedCost monitored the established hospital provider availability standards during the examination period.

The Companies are responsible for establishing policies and procedures which address driving distance standards. The Companies' driving distance standards did not account for local variations in the supply of providers and geographic considerations as required by the provisions of 11 NCAC 20.0302(1).

A. Annual Filings

The Companies' data year 2008 annual filing submissions (MedCost delegated data grids) included driving distance standards which were not consistent with the driving distance standards set forth in the Company policy entitled "Methodology for Determining Provider Availability Targets: Driving Distance" which were submitted during this examination. The submitted policy

outlined the following statewide standards:

- Two PCPs within 30 miles
- One specialist within 30 miles
- One hospital within 30 miles

Item D12 of the annual filing submission provided the following driving distance standards for all provider types:

- Urban – within 15 miles
- Suburban – within 25 miles
- Rural – within 50 miles

B. Out-of-Network Access Disclosure

The Companies stated that enrollees are made aware, via their benefit contract, that they may access out-of-network providers without penalty when in-network providers are not reasonably available. The Companies also stated that they do not disclose this information to enrollees in any other written format. Upon review of the benefit contracts, the Department noted that this information was not disclosed in all of the benefit contracts utilized during the examination period. The benefit contracts which did not sufficiently address the provisions of NCGS 58-3-200(d) include the following forms:

Time Insurance Company Forms

- 244 Save Right HSA Elite
- 244 Right Start HSA Elite
- 244 Save Right HSA
- 244 Right Start

John Alden Life Insurance Company Forms

- 380 Save Right
- 380 Right Start

Therefore, the Companies did not adhere to the provisions of 11 NCAC 12.1804(b) as they failed to provide a comprehensive explanation of the PPO benefit plan to all of their enrollees during the examination period.

C. Provider Directories

The Companies could not provide a copy of the 2008 provider directory for MedCost and PHCS. Therefore, the Companies did not adhere to the provisions of 11 NCAC 19.0102 and 19.0106. In addition, the March 2007 PHCS provider directory did not indicate whether the provider was accepting new patients and did not indicate if there were any other restrictions that would limit access to particular providers. Therefore, the Companies did not adhere to the provisions of NCGS 58-3-245(b)(3).

PHCS/MultiPlan has established the following appointment wait time standards in accordance with the provisions of 11 NCAC 20.0302(4):

- Routine appointment – Six weeks
- Specialist appointment – Four weeks
- Urgent appointment – One week

The Department noted that the urgent care standard was outside the industry norm which typically ranges from 24-48 hours (with 72 hours as the outer limit).

The Companies did not adhere to the provisions of 11 NCAC 20.0304 as they could not produce documentation to demonstrate that PHCS/MultiPlan had monitored provider appointment wait time standards during 2007 and 2008. The Companies stated that PHCS/MultiPlan annually gathers information from sample populations via email and/or telephone and that the information is then reviewed to make certain that appointment wait time standards are met. However, the Companies did not provide any documentation to demonstrate that monitoring occurred during the examination period.

Utilization Management

The Companies delegated their utilization management activities to WellPath Select, Inc. The Companies did not adhere to the provisions of NCGS 58-50-61(b) as they failed to conduct proper oversight of the delegated entity's utilization management activities. Instead of conducting their own annual oversight to ascertain compliance with the provisions of NCGS 58-50-61, the Companies solely relied on the delegated entity's American Accreditation Health Care Commission (URAC) accreditation, which does not provide sufficient oversight to meet the statutory requirements.

In addition, the Companies' own "Delegated Management Functions: Evaluation and Oversight" policy did not adhere to the provisions of NCGS 58-50-61(b) as it stated that only organizations which are not URAC accredited will require the annual completion of the evaluation/oversight form. In North Carolina, accreditation or certification by an accrediting body does not supplant the requirements of the insurer to conduct its own monitoring to provide for statutory compliance.

Utilization Management Policies and Procedures

The Companies' own "Utilization Management Process – North Carolina" policy and procedures (versions 3 and 4) failed to state specifically that a noncertification notice for prospective, concurrent, and retrospective reviews must include notice of external review rights and the availability of the Managed Care Patient Assistance Program (MCPAP), including the telephone number and address of the Program. Therefore, the Companies did not adhere to the provisions of NCGS 58-50-77(a) and 58-50-61(h) respectively. In addition, the Companies' own "Utilization Management Process – North Carolina" policy and procedures (version 3) failed to state specifically that a noncertification notice for an expedited appeal must include notice of external review rights, and did not adhere to the provisions of NCGS 58-50-77(a).

Telephone Access

The Utilization Management department is available to providers and members 40 hours per week through a toll-free telephone line, in accordance with the provisions of NCGS 58-50-61. After normal business hours, a departmental voice mail service is used to accept calls. Calls are returned within one business day by the appropriate utilization management staff.

Standards for telephone accessibility have been established in accordance with the provisions of NCGS 58-50-61. The department monitors actual performance for calls abandoned and average speed to answer. Review of the telephone reports revealed that the Companies failed to meet their own established service level standards in 2007 and 2008, with exception of the call abandonment standard which was met throughout the examination period.

Medical Necessity Reviews

The scope of utilization management services provided includes prospective review for hospital admissions and ambulatory care and services, concurrent review of inpatient health services, retrospective review, referral management, complex case management, and discharge planning.

The Companies appear to handle emergency notification in accordance with the provisions of NCGS 58-3-190, which require that the health plan not condition coverage of emergency care upon the member's notification of the receipt of such services.

A. Prospective Records Review (PPO)

Since the Companies did not conduct any monitoring of the delegated precertification review process, the Department assessed the Companies' precertification review process for compliance with statutory requirements as to timeliness of review, member notification of the results of the review, and other review procedures. The Companies provided a listing of 385 precertification request files. Fifty files were randomly selected for review. A review of precertification requests revealed the following:

- In seven cases (14.0 percent error ratio), the determination was not communicated within three business days after receiving all necessary information, and did not adhere to the provisions of NCGS 58-50-61(f).

- In four cases (8.0 percent error ratio), a medical doctor licensed to practice medicine in the state of North Carolina did not evaluate the clinical appropriateness of the noncertification, and did not adhere to the provisions of NCGS 58-50-61(d).

- In one case (2.0 percent error ratio), a copy of the noncertification letter was not maintained in the file, and did not adhere to the provisions of NCGS 58-50-61(n).

In addition, the Companies did not adhere to their own policies and procedures in the following instances:

- In two cases (4.0 percent error ratio), the Companies failed to demonstrate that they verbally and/or in writing had communicated the certification to the insured.

- In one case (2.0 percent error ratio), the Companies failed to follow their own "Lack of Information Policy" as a second attempt to obtain necessary clinical information via telephone call or fax was not placed/documented after making the initial contact.

The average service time to review and send notification of a prospective decision was two business days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	49	98.0
8 - 14	1	2.0
Total	**50**	**100.0**

Prospective Records Review (Life and Health)

The Companies provided a listing of 72 prospective review files. Fifty files were randomly selected for review.

Two prospective review files (4.0 percent error ratio) were invalid receipts because they represented retrospective reviews. The review was based on the remaining 48 files.

Seven prospective review files (14.6 percent error ratio) evidenced the review was not completed and communicated to the provider within three business days. The Companies did not adhere to the provisions of NCGS 58-50-61(f).

B. Concurrent Records Review (PPO)

Since the Companies did not conduct any monitoring of the delegated concurrent review process, the Department assessed the Companies' concurrent review process for compliance with statutory requirements as to timeliness of review, member notification of the results of the review, and other review procedures. The Companies provided a listing of 383 concurrent review files. Fifty files were randomly selected for review. A review of concurrent review requests revealed the following:

- In one case (2.0 percent error ratio), the determination was not communicated within three business days after receiving all necessary information, and thus did not adhere to the provisions of NCGS 58-50-61(f).

In addition, the Companies did not adhere to their own policies and procedures in the following instances:

- In two cases (4.0 percent error ratio), the Companies failed to demonstrate that they verbally and/or in writing had communicated the certification to the insured.

- In one case (2.0 percent error ratio), the Companies failed to follow their own "Lack of Information Policy" as a second attempt to obtain necessary clinical information via telephone call or fax was not placed/documented within two calendar days after making the initial contact.

The average service time to review and send notification of a concurrent decision was one business day. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	50	100.0
Total	**50**	**100.0**

Concurrent Records Review (Life and Health)

The Companies provided a listing of 50 concurrent review files. All files were reviewed.

Three concurrent review files (6.0 percent error ratio) were invalid receipts as one file represented a retrospective review, and two files were duplicate records

C. Retrospective Records Review (PPO)

Since the Companies did not conduct any monitoring of the delegated retrospective review process, the Department assessed the Companies' retrospective review process for compliance with statutory requirements as to timeliness of review, member notification of the results of the review, and other review procedures. The Companies provided a listing of 382 retrospective review files. Fifty files were randomly selected for review. A review of the retrospective review files revealed the following:

- In two cases (4.0 percent error ratio), written noncertification notification to the member did not include the member's right to an external review, and the Companies did not adhere to the provisions of NCGS 58-50-61 and 58-50-77(a)(1).

- In one case (2.0 percent error ratio), the noncertification review was not evaluated by a medical doctor licensed to practice medicine in the state of North Carolina, and the Companies did not adhere to the provisions of NCGS 58-50-61(d).

- In one case (2.0 percent error ratio), the noncertification notification was not sent to the covered person and the covered person's provider, and the Companies did not adhere to the provisions of NCGS 58-50-61(g).

In addition, the Companies did not adhere to their own policies and procedures in the following instances:

- In 14 cases (28.0 percent error ratio), the Companies failed to communicate the certification to the insured and/or the provider within one business day of the determination.

The average service time to review and send notification of a retrospective review decision was nine business days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	20	40.0
8 - 14	23	46.0
15 - 21	7	14.0
Total	**50**	**100.0**

Retrospective Records Review (Life and Health)

The Companies provided a listing of 42 retrospective review files. All files were reviewed.

Two retrospective review files (4.8 percent error ratio) were invalid receipts as one

represented a prospective review and one was a Medicare primary claim that did not require review. The review was based on the remaining 40 files.

Four retrospective review files (10.0 percent error ratio) showed evidence that the review was not completed within 30 days after receiving all necessary information. The Companies did not adhere to the provisions of NCGS 58-50-61(g).

Thirteen retrospective review files (32.5 percent error ratio) showed evidence that the notification of certification was not made available to the provider within one day. The Companies did not adhere to their own policies and procedures.

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Companies' decision. A member is entitled to an expedited review of his/her appeal if a delay in the rendering of health care would be detrimental to his/her health.

Appeal Records Review

Since the Companies did not conduct any monitoring of the delegated appeal process, the Department assessed the Companies' appeal process for compliance with regulatory requirements as to member notification of the results of the review. The Companies provided a listing of 23 appeals. All appeal files were reviewed. Review of the appeal files revealed the following violations of statutory and/or regulatory requirements:

- In three files (13.0 percent error ratio), the acknowledgment letter was not sent within three business days of the request. The Companies did not adhere to the provisions of NCGS 58-50-61.

The average service time to review and send notification of an appeal decision was 17 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	6	26.1
8 - 14	3	13.0
15 - 21	6	26.1
22 - 30	8	34.8
Total	**23**	**100.0**

Provider Credentialing

During the examination period, the Companies did not establish a formal delegated credentialing oversight process. Therefore, the Companies did not adhere to the provisions of 11 NCAC 20.0410(1) and (3), as they failed to demonstrate to the Department that they had conducted the required oversight of the credentialing functions delegated to the following entities:

- MedCost
- PHCS/MultiPlan
- WellPath Select, Inc.

In addition, the Companies did not adhere to the provisions of 11 NCAC 19.0102(a) and 19.0106(d), as they failed to maintain quarterly provider updates from PHCS/MultiPlan as required by the provisions of 11 NCAC 20.0410(2).

UNDERWRITING PRACTICES (LIFE AND HEALTH)

Individual Accident and Health Issued

The Companies provided a listing of five individual accident and health issued files. All policy files were reviewed.

One policy file (20.0 percent error ratio) represented a substandard issued policy and was excluded from the population. The review was based on the remaining four policy files.

One policy file (25.0 percent error ratio) contained an application that was signed and dated prior to the producer's appointment. The Companies did not adhere to the provisions of NCGS 58-33-26 and 58-33-40.

The average service time to underwrite and issue a policy was one calendar day. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 – 7	4	100.0
Total	**4**	**100.0**

Individual Accident and Health Declined

The Companies supplied a listing of 75 individual accident and health declined files. Fifty files were randomly selected for review.

Three application files (6.0 percent error ratio) contained an application that was signed and dated prior to the producer's appointment. The Companies did not adhere to the provisions of NCGS 58-33-26 and 58-33-40.

Two application files (4.0 percent error ratio) did not contain evidence that an AUD notice was provided to the applicant, policyholder, or individual proposed for coverage.

The average service time to underwrite and decline an application was 22 calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	10	20.0
8 - 14	9	18.0
15 - 21	7	14.0
22 - 30	15	30.0
31 - 60	6	12.0
Over 60	3	6.0
Total	**50**	**100.0**

Individual Accident and Health Issued Substandard

The Companies provided a listing of 30 individual accident and health issued substandard files. All files were reviewed.

Three policy files (10.0 percent error ratio) did not contain evidence that an AUD notice was provided to the applicant, policyholder, or individual proposed for coverage. The Companies did not adhere to the provisions of NCGS 58-39-55.

Two policy files (6.7 percent error ratio) contained an application that was signed and dated prior to the producer's appointment. The Companies did not adhere to the provisions of NCGS 58-33-26 and 58-33-40.

The average service time to underwrite and issue an application was 11 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	14	46.6
8 - 14	8	26.7
15 - 21	5	16.7
22 - 30	2	6.7
31 - 60	1	3.3
Total	**30**	**100.0**

Individual Major Medical Issued

The Companies provided a listing of 25,182 individual major medical issued files. One hundred files were randomly selected for review.

Two policy files (2.0 percent error ratio) contained an application that was signed and dated prior to the producer's appointment. The Companies did not adhere to the provisions of NCGS 58-33-26 and 58-33-40.

The average service time to underwrite and issue a policy was three calendar days. A chart of the average service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	93	93.0
8 - 14	6	6.0
15 - 21	1	1.0
Total	**100**	**100.0**

Individual Major Medical Declined

The Companies provided a listing of 66 individual major medical declined files. Fifty files were randomly selected for review.

Twenty-two application files (44.0 percent error ratio) did not contain evidence that an AUD notice was provided to the applicant, policyholder, or individual proposed for coverage; or contained an AUD notice that was neither filed with nor approved by the Department. The Companies did not adhere to the provisions of NCGS 58-39-55.

The average service time to underwrite and decline an application was 19 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	17	34.0
8 - 14	8	16.0
15 - 21	4	8.0
22 - 30	9	18.0
31 - 60	10	20.0
Over 60	2	4.0
Total	**50**	**100.0**

Individual Major Medical Issued Substandard

The Companies provided a listing of eight individual major medical issued substandard files. All files were reviewed. No adverse trends or unfair trade practices were observed in this section of the examination.

One policy file (12.5 percent) represented a Georgia policy and was excluded from the population. The review was based on the remaining seven policy files.

The average service time to underwrite and issue a policy was one calendar day. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 – 7	1	14.3
8 – 14	1	14.3
15 – 21	3	42.8
22 – 30	2	28.6
Total	**7**	**100.0**

Small Employer Group Issued

The Companies provided a listing of three small employer group issued files. All files were reviewed. No adverse trends or unfair trade practices were observed in this section of the examination.

POLICY RESCISSIONS (LIFE AND HEALTH)

Individual Major Medical Policy Rescissions

The Companies provided a listing of 32 individual major medical policy rescission files. All files were reviewed.

One rescission policy file (3.1 percent) was excluded from the review because the file represented a modification and not a rescission. The review was based on the remaining 31 rescission policy files. No adverse trends or unfair trade practices were observed in this section of the examination.

Eight rescission policy files (25.0 percent) did not begin with the submission of a claim, therefore no refund service days from the date the claim was received could be ascertained. The refund service days figure was based on the 31 rescission policy files that were initiated with a claim submission. The average service time to process a rescission refund was 148 calendar days. A chart of the refund service time follows:

Service Days	Number of Files	Percentage of Total
31 - 60	2	8.7
Over 60	21	91.3
Total	**23**	**100.0**

SPECIAL CONCERNS (PPO)

Based on the Department's findings in the Companies' PPO marketing materials, which incorrectly stated that a covered person who seeks non-network emergency services is responsible for paying the provider any balance in excess of the negotiated rate, and the Companies' subsequent disagreement with the Department's findings, the Department along with its legal counsel met with the Companies' legal counsel and Vice President Regulatory Compliance and Compliance Officer to discuss the issue further. During the August 21, 2012, meeting, the Department explained to the Company representatives that NCGS 58-3-200(d) does

not allow an insured to be penalized or subjected to out-of-network benefit levels unless in-network providers able to meet the health needs of the insured are reasonably available to the insured without unreasonable delay. Therefore, in these circumstances, the Companies cannot hold the insured liable for any balance (after any applicable co-pay/co-insurance) in excess of the in-network rate. On the same date of the meeting, the Companies were instructed to conduct a review on all out-of-network emergency claims adjudicated from January 1, 2007, through August 31, 2012, as well as inpatient ancillary claims which included services rendered by a non-participating provider. The Companies were further instructed to reprocess the claims in accordance with the statutory provisions as detailed by the Department's counsel during the August 21, 2012, meeting. In the Companies' response dated September 25, 2012, the Companies declined to take any action to reprocess the claims.

The requested claims data was received from the Companies in batches to the Department from December 2012 through March 2013. The number of claims processed by each Company is provided in the following chart:

Assurant, Inc. Company Name	Claim Files
John Alden Life Insurance Company	458
Time Insurance Company	1,058
Total	**1,516**

The Department's review of the 1,516 claims revealed that four John Alden Insurance Company claims and 67 Time Insurance Company claims revealed no issues. A review of the 1,516 claims from the two Companies revealed the claims were not processed in accordance with the provisions of NCGS 58-3-200(d) and/or 58-3-300(d), and also revealed one or more of the following issues:

- Incorrect application of reasonable and customary (R&C) rates while holding member liable for the difference between R&C and the billed charges (after application of co-pay/co-insurance);

- Incorrect application of incurred claim amounts to the member's out-of-network deductible instead of the in-network deductible (and only up to the R&C amount);

- Incorrect processing of claims yielded incorrect accumulators/deductibles for the benefit period, which could potentially affect other claims processed during the same benefit period for the insured and/or any dependents.

On April 11, 2013, the Department instructed the Companies to review and reprocess each claim in question in accordance with the provisions of NCGS 58-3-190(d) and/or 58-3-200(d). The Companies were instructed to record remedial action and to submit supporting documentation, including but not limited to refunds with applicable interest, to the Department no later than May 31, 2013. The Companies submitted their response to the Department on May 31, 2013, stating the following:

> "*Thank you for meeting with Bonni Fredrick, Senior Counsel II and Julia Hix, Vice President Regulatory Compliance and Compliance Officer from Assurant Health on August 21, 2012 to discuss the provisions of NCGS 58-3-190(d) and NCGS 58-3-200(d). It was noted during this meeting that the Companies have the option to either agree to the Department's request or decline the Department's request and await the draft examination report and review the final examination issues in total.*
>
> *The Companies respectfully maintain the position that NCGS 58-3-190(d) and NCGS 58-3-200(d), as written, do not prohibit the utilization of reasonable and customary reductions of billed charges for out-of-network services and therefore, declines to reprocess the claims. The Companies request that once it has had an opportunity to review the examination findings in total, that discussions resume with the Department regarding this issue as well as additional examination findings."*

Therefore, the Companies did not adhere to the provisions of NCGS 5-3-190(d) and/or 58-3-200(d) as they failed to process 1,516 claims in accordance with statutory requirements and subsequently declined to reprocess the claims after two separate requests by the Department on August 21, 2012, and again on April 11, 2013.

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

Claims Practices (PPO)

The Company must provide an accurate EOB to claimants to adequately address member liability, include all statutory requirements in denial notifications when requesting additional information, and include statutorily compliant claims processing standards in its written policies and procedures.

Claims Practices (Life and Health)

The Company must pay, deny or notify an insured of all information needed to process a claim within 30 days of receipt of the claim.

Policyholder Treatment (PPO)

The Company must include all statutory requirements in member grievance policies and procedures, in grievance acknowledgment and determination letters, and comply with all applicable statutory timeframes and requirements for processing member grievances, including but not limited to, sending the appropriate acknowledgement, notice of hearing and determination letters.

Marketing (PPO)

The Company must utilize marketing brochures which correctly outline the member's responsibility/liability regarding out-of-network emergency services.

Delegated Oversight (PPO)

The Company, with regards to network activities, must file intermediary agreements and contract forms with the Department and receive approval prior to executing the agreements; submit timely initial certifications for intermediary organizations; demonstrate ongoing oversight of provider contracts utilized by intermediary organizations; monitor accessibility and availability standards for intermediary organizations; and provide all enrollees a comprehensive explanation of the PPO benefit plan. With regards to utilization management activities, the Company must conduct proper oversight of the delegated entity's utilization management activities; maintain ongoing oversight of delegated utilization management policies and procedures regardless of the accreditation status of the delegated entity; maintain appropriate policies and procedures that contain all statutory requirements for processing utilization management prospective, concurrent, and retrospective reviews, as well as utilization management appeals; and have a medical doctor licensed to practice medicine in North Carolina evaluate the clinical appropriateness of

noncertifications. The Company, with regards to provider credentialing activities, must be able to demonstrate that it has conducted the required oversight of credentialing functions delegated to intermediary organizations and maintain quarterly updates received from intermediary organizations.

Underwriting Practices (Life and Health)

The Company must implement controls to not allow applications for coverage to be accepted from producers that are signed and dated prior to the producers' appointment date. Additionally, the Company must use an AUD notice that was filed with and approved by the Department and maintain copies of all notices sent in the applicable files.

Utilization Management (Life and Health)

The Company must process all prospective and retrospective reviews in accordance with statutory requirements and provide the appropriate notifications to providers.

Special Concerns (PPO)

The Company must amend it policies to accurately process out-of-network emergency and inpatient ancillary claims in accordance with statutory requirements.

CONCLUSION

The target examinations have been conducted on the market conduct affairs of John Alden Life Insurance Company and Time Insurance Company for the period of January 1, 2007, through December 31, 2008, with analyses of certain operations of the Companies being conducted through March 2, 2015, for the Life and Health line of business, and January 1, 2007, through December 31, 2008, with analyses of certain operations of the Companies being conducted through March 2, 2015, for the PPO line of business.

The examinations were conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of general

administration, provider relations and delivery system, utilization management, provider credentialing, claims practices, policyholder treatment, marketing, delegated oversight, and underwriting practices.

In addition to the undersigned, Tanyelle Byrd, MBA, MHA, Scott Grindstaff, MHP, HIA, Kim King, HIA, MHP, and Linda Sinclair, ACS, AIRC North Carolina Market Conduct Examiners participated in this examination and in the preparation of this report.

Respectfully submitted,

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Examiner-In-Charge
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I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Tracy Miller Biehn, LPCS, MBA
Deputy Commissioner
Market Regulation Division
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