REPORT ON EXAMINATION

OF THE

HEALTHPLEX INSURANCE COMPANY

AS OF

DECEMBER 31, 2004

DATE OF REPORT **AUGUST 31, 2006**

EXAMINER **ROY ZABALA**

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Howard Mills
Superintendent

August 31, 2006

Honorable Howard Mills
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in compliance with the instructions contained in Appointment Number 22240, dated July 29, 2004, attached hereto, I have made an examination into the condition and affairs of the Healthplex Insurance Company, an accident and health insurance company licensed under the provisions of Article 42 of the New York Insurance Law, as of December 31, 2004, and respectfully submit the following report, thereon.

The examination was conducted at the Company's statutory home office located at 333 Earle Ovington Boulevard, Uniondale, New York.

Wherever the terms "the Company", or "HIC" appear herein, without qualification, they should be understood to indicate Healthplex Insurance Company. Wherever the terms "Healthplex" or "the Parent" appear herein, without qualification, they should be understood to indicate Healthplex, Inc., HIC's parent company.

1. SCOPE OF EXAMINATION

This examination covers the period from May 2, 2001 through December 31, 2004. A previous examination on organization was conducted as of May 1, 2001. Where deemed appropriate, transactions occurring subsequent to December 31, 2004 were also reviewed.

The examination comprised a verification of assets and liabilities as of December 31, 2004 in accordance with Statutory Accounting Principles ("SAP"), as adopted by the Department, a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Company's independent certified public accountants. A review or audit was also made of the following items as called for in the Examiners' Handbook of the National Association of Insurance Commissioners ("NAIC"):

History of the Company
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of Company
Business in force
Reinsurance
Loss experience
Accounts and records
Financial statements
Market conduct activities

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF COMPANY

Healthplex Insurance Company was incorporated on June 12, 1998. The declaration of intention and charter were approved by the State of New York Insurance Department pursuant to Section 1201 of the New York Insurance Law and placed on file with the Department on the same date. It was noted, however, that the Company's Jurat Page in its filed annual statement as of December 31, 2004, incorrectly showed that it was incorporated on July 12, 2000.

It is recommended that the Company include the correct date of its incorporation on the Jurat Page of its filings with this Department.

Healthplex Insurance Company offers dental contracts to groups and individuals in the New York metropolitan area, although the Company focuses almost solely on small groups. The Company began writing business in March 2003.

A. Management and Controls

Pursuant to the Company's charter and by-laws, management of the Company is to be vested in a board of directors consisting of not less than thirteen (13), nor more than twenty one (21) members. As of the examination date, the Board of Directors was comprised of thirteen members. The thirteen board members and their principal business affiliations as of December 31, 2004, were as follows:

Name and Residence	Principal Business Affiliation
Dr. Michael Carnicelli St. Augustine, FL	Retired
Karen Cuchel Brooklyn, NY	Teacher, Great Neck School District
Dr. Stephen Joseph Cuchel Roslyn Harbor, NY	Chairman of the Board, Healthplex, Inc.
Stuart W. Fenton Beachwood, OH	Vice President, ING Funds Distributor, LLC
Dr. George Kane Southhampton, NY	Vice President and Treasurer, Healthplex, Inc.
Martha Kane Hewlett Harbor, NY	Retired
Dr. Martin Kane Hewlett Harbor, NY	President, Healthplex, Inc.
Douglas King Stuart, FL	Retired
Dr. Stephen Leibowitz Morganville, NJ	Dental Consultant, Healthplex, Inc.
Joanne Malin Garden City, NY	Assistant Vice President, Healthplex, Inc.
Philip John Rizzuto Jr. North Merrick, NY	Vice President of Computer Operations, Healthplex, Inc.
Dr. Bruce Henry Safran Manhasset, NY	Vice President, Healthplex, Inc.
George Wang New York, NY	Attorney, Thelen, Reid & Priest LLP

According to its by-laws, HIC's board is required to meet once a year for an annual meeting, and may hold special meetings as desired. The Board of Directors of HIC met once per calendar year (three times) during the period January 1, 2002 through December 31, 2004. A review of the minutes of the Board of Directors' meetings indicated that meetings were generally well attended; with all board members attending at least 50% of the meetings for which they were eligible.

Although HIC's board meets once a year, in compliance with the requirements of its by-laws, there is a concern that the infrequency of these meetings does not allow the board to fulfill its fiduciary duty and provide adequate oversight of the operations of the Company. The board should meet at least four (4) times per calendar year (preferably every quarter) to review the performance and activities of the Company.

It is recommended that the Company amend its by-laws to require its board to meet a minimum of four times per calendar year.

The principal officers of the Company as of December 31, 2004 were as follows:

Officers	Title
Martin Kane	President
Bruce Henry Safran	Secretary
George Kane	Treasurer

A review of HIC's investment portfolio revealed that the Board of Directors was responsible for, and approved all investment transactions during the examination period. However, the Company does not follow any formal written investment guidelines. Although the Company's investments as of the examination date consisted mainly of short-term U.S. Treasury Bonds, the Department regards the development and oversight of investment guidelines to be a prudent business practice.

It is recommended that the Company adopt and abide by formal written investment guidelines for all future investments.

B. Territory and Plan of Operation

Healthplex Insurance Company is licensed pursuant to Article 42 of the New York Insurance Law and is authorized to write accident and health insurance as defined in paragraphs 3(i) and (ii) of Section 1113(a) of the New York Insurance Law. Healthplex Insurance Company is licensed to conduct business only in New York State.

The Plan's direct premiums written ("DPW") and enrollment during the three-year examination period were as follows:

Calendar Year	Direct Premiums Written	Enrollment
2002	*	*
2003	$384,280	3,263
2004	$1,069,893	2,660

* Healthplex Insurance Company began operations in March 2003.

In 2005, subsequent to the examination date, the Company's direct premiums written and enrollment decreased to $944,625 and 2,396, respectively.

The following compares the Company's "Actual" amounts for DPW for the first three years of operation, versus the Company's "Projected" amounts as shown in its Business Plan submitted to the Department as part of the licensing process:

Year *	Projected DPW	Actual DPW	Variance
2003	$1,000,000	$384,280	$(615,720)
2004	$1,150,000	$1,069,893	$(80,017)
2005	$1,322,500	$944,265	$(378,235)

* Corresponds to projections for the Company's first three years of operation. Note that 2005 is subsequent to the examination period.

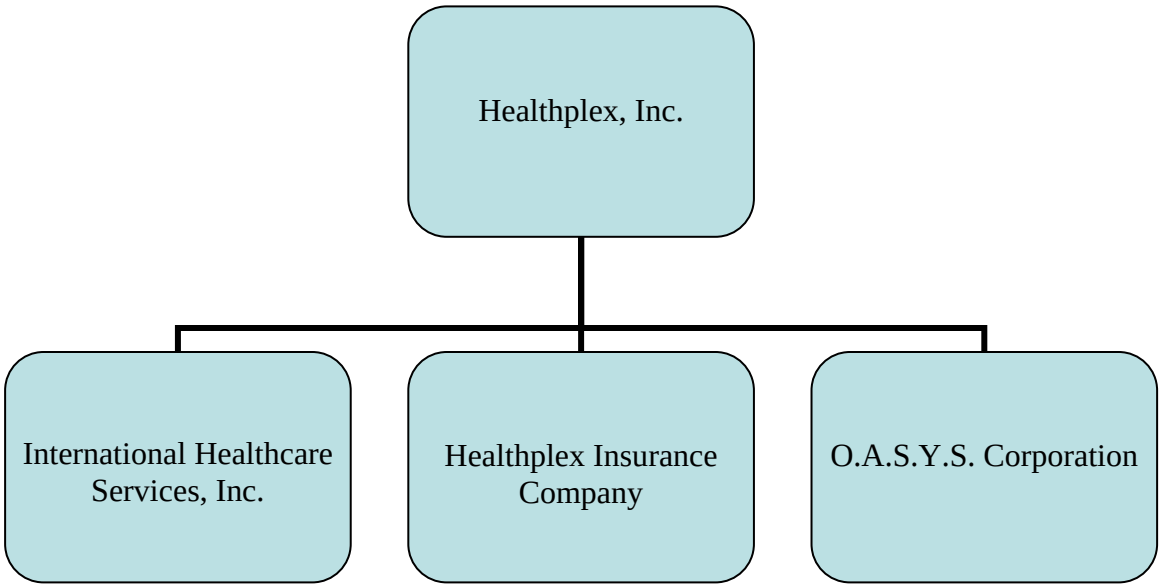
As is denoted in the above chart, the Company has not met its projected premium writings. In fact, after a convergence in 2004, in 2005 there was a large variance between "Actual" and "Projected" premium revenue, with Actual premium revenue falling. This failure to grow its business and meet its projected premium writings, in conjunction with the financial transactions entered into with its Parent (detailed in Section 2C below), that were used to enhance the Company's financial condition are a cause for concern, and merit further scrutiny of the Company's continued operations.

Thus, it is recommended that the Company file an amended Business Plan with this Department detailing its operations for the next three years, including any expected financial support from its Parent. This Business Plan must include financial and enrollment projections, including the enrollment amount needed to break even.

C. Holding Company System

Healthplex Insurance Company is a wholly-owned subsidiary of Healthplex, Inc., a privately held New York Corporation. As a member of a holding company system, HIC is required to file registration statements pursuant to the requirements of Article 15 of the New York Insurance Law and Department Regulation 52 (11 NYCRR 80). The Company made all its pertinent filings regarding the aforementioned statutes during the examination period.

The structure of the holding company system as of the examination date was as follows:



HIC does not have any employees and the business operations and affairs of the Company are effected by Healthplex, Inc. (“the Parent”) pursuant to the terms of an Administrative Services Agreement. The services covered by this Agreement include, but

are not limited to: marketing, management, claims processing, electronic data processing, consulting, and administrative services. The Administrative Services Agreement has an effective date of January 1, 2000, and was approved by the Department on January 3, 2000, pursuant to Section 1505(d)(3) of the New York Insurance Law.

The Company also entered into a consolidated Tax Allocation Agreement with an effective date of March 29, 1999 with its Parent. This Agreement was found to be consistent with the guidelines contained in Circular Letter No. 33 (1979), and was approved by the Department on March 9, 1999, pursuant to Section 1505(d)(3) of the New York Insurance Law.

A review of the Company's holding company transactions that occurred during the examination period revealed that the Company completed certain transactions in 2004 with its Parent that appeared to be violative of various Department statutes and Regulations. These are detailed as follows:

Healthplex made advance payments to HIC on February 24, 2004 and March 31, 2004, in the amounts of $30,000 and $5,000, respectively. The Department interprets these like transactions to be combined for the purposes of regulatory approval.

Section 1505(c) of the New York Insurance Law states:

> "The superintendent's prior approval shall be required for the following transactions between a domestic controlled insurer and any person in its holding company system: sales, purchases, exchanges, loans or extensions of credit, or investments, involving five percent or more of the insurer's admitted assets at last year-end."

The above advance payments and subsequent repayment by HIC to its Parent in 2004 ($20,000 in October and $15,000 in December), exceeded five (5) percent of the Company's admitted assets as of December 31, 2003. As a result, the Company violated Section 1505(c) of the New York Insurance Law, when it failed to request and receive approval from the Superintendent, prior to entering into the transactions.

In addition, there was no board resolution from the Company's Parent detailing the purpose of these advance payments and whether they were subject to repayment and thus should have been recorded by the Company as a liability. Further, there is concern that since these advance payments were included in the Company's assets in its quarterly statement filings with this Department, the Company's financial status was distorted.

It is recommended that the Company comply with the requirements of Section 1505(c) of the New York Insurance Law.

In addition, Healthplex "waived" an expense in the amount of $208,318 (for broker commissions) due from the Company. Section VIII of the Company's Administrative Services Agreement ("Agreement") with Healthplex contains the following provision:

> *"The Plan shall compensate Healthplex for all services rendered hereunder in accordance with the terms of Exhibit 1, attached hereto and made a part hereof. Such compensation shall at all times be: (i) the amount computed by the methodology detailed in Exhibit 1 of this Agreement or (ii) a lesser amount mutually agreed to by Healthplex and the Plan."*

Although the Company's Agreement allows for a "mutual settlement" of inter-company transactions to occur, the Department was not notified of the above transaction, nor did it appear in the Company's financial statements, supporting schedules or notes contained in the annual statement filed with this Department. Additionally, this transaction was not recorded in the Company's financial statements as a "capital contribution" and thus misrepresented the true financial condition of the Company. This is particularly important since had the amount waived actually been paid by the Company, it would have impaired its surplus and made it subject to additional regulatory oversight by this Department.

Section 1505(b) of the New York Insurance Law which pertains to transactions within a holding company system affecting controlled insurers states:

> "The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties."

The Company failed to comply with the above statute when it entered into the aforementioned transaction with its Parent.

It is recommended that the Company comply with the requirements of Section 1505(b) of the New York Insurance Law.

In addition, the Company failed to comply with the disclosure requirements and underlying accounting principles detailed in Statement of Statutory Accounting Principles (SSAP) No. 25 (Accounting for and Disclosures about Transactions with Affiliates and Other Related Parties), which was adopted by Department Regulation 172 (11 NYCRR 83).

It is recommended that the Company comply with the requirements of SSAP No. 25.

Further, it appears that the Company failed to comply with the requirements of Section 307(a)(1) of the New York Insurance Law, which states in part:

> (a)(1) Every insurer and every fraternal benefit society which is authorized to do an insurance business in this state,… shall file in the office of the superintendent, annually on or before the first day of March, a statement, to be known as its annual statement, executed in duplicate, verified by the oath of at least two of its principal officers, showing its condition at last year-end…"

It would appear that the failure to properly document and account for the above inter-company transactions has obscured the Company's actual financial condition. This is violative of Section 307(a)(1) of the New York Insurance Law, in that the annual statement sworn to and filed with this Department was not indicative of its true financial condition.

It is recommended that the Company's officers comply with the requirements of Section 307(a)(1) of the New York Insurance Law by filing complete and accurate annual statements with this Department.

Inasmuch as the capital contribution from HIC's Parent suggests a deteriorating financial condition, it is recommended that the Administrative Services Agreement be amended so that any settlements or forgiveness of debt in regard to all inter-company transactions would be subject to regulatory approval under Article 15 of the New York Insurance Law. Furthermore, this action requires that the amended Administrative Services Agreement be provided to the Department for approval under the provisions of Article 15 of the New York Insurance Law.

It is recommended that the Company properly record all capital contributions in its financial statements filed with this Department.

D. Significant Operating Ratios

The underwriting ratios presented below are on an earned-incurred basis and encompass the period covered by this examination:

	Amounts	**Ratios**
Claims incurred	$1,473,152	101%
Claims adjustment expenses incurred	0	0%
General administrative expenses incurred	217,277	15%
Net underwriting loss	(236,256)	(16%)
Premiums earned	$1,454,173	100%

E. Reinsurance

The Company neither assumed nor ceded any reinsurance during the examination period.

F. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with Statutory Accounting Principles as adopted by Department Regulation 172 or annual statement instructions. A description of such items is as follows:

1. During the review of Part 3 of the Company's "Underwriting and Investment Exhibit – Analysis of Expenses", it was noted that all expenses were reported in "General Administrative Expenses" (column 3). The Company failed to allocate its expenses within the appropriate categories contained in Part 3 of the Underwriting and Investment Exhibit, in accordance with Department Regulation 33 (Allocation of Income (Receipts) and Expenses (11 NYCRR 91)) and the annual statement instructions.

It is recommended that the Company complete Part 3 of its Underwriting and Investment Exhibit in accordance with the requirements of Department Regulation 33 and the annual statement instructions.

2. Paragraph 6 of the Statement of Statutory Accounting Principles (SSAP) No. 26 states:

> "Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)."

A review of the Company's Scheduled D – Part 1 revealed that the Company applied the straight line method for the amortization of its bond premium, rather than the scientific (interest rate) method prescribed by SSAP No. 26. As the Company had a small bond portfolio, the amortization variance was immaterial and no change was made to the financial statements contained herein.

It is recommended that the Company comply with the amortization methodology prescribed in Paragraph 6 of SSAP No. 26 when calculating the amortized value of its bonds.

3. As of the examination date, the Company's securities were held with a bank pursuant to a custodial agreement. This Department requires that custodial agreements contain certain provisions in order to ensure that an insurer's assets are properly safeguarded. A review of the Company's custodial agreement indicated that it was lacking the following protective covenant:

> "That during regular business hours, and upon reasonable notice, an officer or employee of the insurance company, an independent accountant selected by the insurance company and a representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, its records relating to securities, if the custodian is given written instructions to that effect from an authorized officer of the insurance company."

It is recommended that the Company amend its custodial agreement to include the above provision in order to provide its assets with the necessary safeguards.

4. Paragraph 9(a) of Statement of Statutory Accounting Principles (SSAP) No. 6 states in part:

> "9. Non-admitted amounts are determined as follows:
>
> a. Uncollected Premium - To the extent that there is no related unearned premium, any uncollected premium balances which are over ninety days due shall be nonadmitted. If an installment premium is over ninety days due, the amount over ninety days due plus all future installments that have been recorded on that policy shall be nonadmitted…"

Further, Section 1301(a)(11) of the New York Insurance Law states in part:

> "(a) In determining the financial condition of a domestic or foreign insurer or the United States branch of an alien insurer for the purposes of this chapter, there may be allowed as admitted assets of such insurer, unless otherwise specifically provided in this chapter, only the following assets owned by such insurer:
>
> (11) Premiums in course of collection, other than life insurance premiums, not more than ninety days past due, less commissions payable thereon."

A review of the Company's aged accounts receivable balances revealed that the Company failed to classify a portion of the receivables that was over ninety (90) days due as a "non-admitted asset". The amount overdue was deemed immaterial and therefore no change was made to the financial statements contained herein.

It is recommended that the Company report all premiums receivable over ninety (90) days due as non-admitted, as prescribed by Section 1301(a)(1) of the New York Insurance Law and Paragraph 9(a) of SSAP No. 6, in its filings with this Department.

5. In Section 2C of this report, the examiner noted a capital contribution in the form of “forgiveness of debt” that the Company failed to properly account for. The Company did not record commission expense, establish the corresponding liability that was ultimately waived, nor did it account for the resulting capital contribution in its books and accounts, and in its financial statements filed with this Department.

In addition, in Section 2C of this report, the examiner noted that the Company received advance payments from its Parent in 2004, which were subsequently repaid by the Company later that same year. However, these advance payments were never recorded by the Company as a liability.

It is recommended that the Company properly account for and disclose all transactions in its books and accounts, and in its financial statements filed with this Department.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities, and surplus as determined by this examination as of December 31, 2004. This is the same as the balance sheet filed by the Company in its December 31, 2004 annual statement:

Assets	Examination	Company
Bonds	$ 505,425	$ 505,425
Cash and short term investments	56,420	56,420
Subtotal, cash and invested assets	$ 561,845	$ 561,845
Investment income due and accrued	8,540	8,540
Uncollected premiums and agents' balances in the course of collection	16,763	16,763
Total assets	$ 587,148	$ 587,148
Liabilities		
Claims unpaid	$ 85,083	$ 85,083
Premiums received in advance	17,842	17,842
General expenses due or accrued	192	192
Amounts due to parent, subsidiaries and affiliates	91,944	91,944
Total liabilities	$ 195,061	$ 195,061
Capital and Surplus		
Common capital stock	$ 300,000	$ 300,000
Gross paid in and contributed surplus	209,500	209,500
Unassigned funds (surplus)	(117,413)	(117,413)
Total capital and surplus	$ 392,087	$ 392,087
Total liabilities, capital and surplus	$ 587,148	$ 587,148

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2004. The examiner is unaware of any potential exposure of the Company to any tax assessments and no liability has been established herein relative to such contingency.

B. Underwriting and Investment Exhibit

Capital and surplus decreased by $154,420, during the examination period of May 2, 2001 through December 31, 2004, detailed as follows:

Revenue			
Premium earned	$ 1,454,173		
Other income or expenses	1,087		
Net investment gain	84,376		
Total revenue		$ 1,539,636	
Expenses			
Hospital and medical	$ 1,473,152		
General administrative expenses	217,277		
Federal and foreign income taxes incurred	3,627		
Total expenses		$ 1,694,056	
Net loss		$ (154,420)	
Change in Capital and Surplus			
Capital and surplus per report on organization as of May 1, 2001			$ 546,507
	Gains in Surplus	Loss in Surplus	
Net loss		$ (154,420)	
Net decrease in capital and surplus			$ (154,420)
Capital and surplus per report on examination as of December 31, 2004			$ 392,087

4. UNPAID CLAIMS RESERVES

The examination liability of $85,083 for the captioned account is the same as that reported by the Company in its filed annual statement as of December 31, 2004.

The examination analysis of the unpaid claims reserve was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Company's internal records and in its filed annual statements as verified during the examination.

5. UNPAID CLAIMS ADJUSTMENT EXPENSES

The Company did not report any amount nor show any payments made during the examination period for the captioned liability. Section 1303 of the New York Insurance Law, which requires that a liability be established in an amount estimated to provide for the expenses for the adjustment or settlement of all losses states in part:

> "Every insurer shall, … maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims incurred on or prior to the date of statement, whether reported or unreported, which are unpaid as of such date and for which such insurer may be liable, and also reserves in an amount estimated to provide for the expenses of adjustment or settlement of such losses and claims."

It is recommended that the Company establish and maintain reserves for unpaid claims adjustment expenses as prescribed by Section 1303 of the New York Insurance Law.

6. MARKET CONDUCT

In the course of this examination, a review was made of the manner in which the Company conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct investigation. The review was directed at the practices of the Company in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Explanation of benefits statements
D. Underwriting

A. Claims processing

A review of the Company's claims practices and procedures was performed by using a statistical sample covering claims adjudicated during the period of January 1, 2004 through December 31, 2004, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiner selected a sample of 167 claims for review. It should be noted that the Company only writes dental insurance.

This statistical random sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each

attribute individually, or on a collective basis, could be concluded for each item in the sample.

For the purpose of this report, a "claim" as defined by HIC, is the total number of items submitted by a single provider with a single claim form, as reviewed and entered into its claims processing system. This claim may consist of various lines, procedures or service dates. It was possible, through the computer systems used for this examination, to match or "roll-up" all procedures on the original form into one item, which was the basis of the Department's statistical sample of claims or the sample unit. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by HIC for the period January 1, 2004 through December 31, 2004, and included in its annual statement filed with the Department for calendar year 2004.

The examination review revealed that the overall claims processing financial accuracy level was 86.23% and the overall claims processing procedural accuracy level was also 86.23%. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim was processed in accordance with HIC's claim processing guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such, it is counted both as a financial error and a procedural error. In summary, of the 167 claims reviewed, there were 23 procedural errors, which resulted in 23 financial errors.

The following tables summarize the claims processing errors:

Summary of Financial Accuracy

Population	5,533
Sample Size	167
Number of claims with errors	23
Calculated Error Rate	**13.77%**
Calculated Accuracy Rate	**86.23%**
Upper error limit	19.00%
Lower error limit	8.55%
Calculated Claims in Error	**762**
Upper limit claims in error	1,051
Lower limit claims in error	473

Note: The upper and lower error limits represent the range of potential error (e.g. if 100 sample items were selected the rate of error would fall between these limits 95 times.)

Summary of Procedural Accuracy

Population	5,533
Sample Size	167
Number of claims with errors	23
Calculated Error Rate	**13.77%**
Calculated Accuracy Rate	**86.23%**
Upper error limit	19.00%
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Calculated Claims in Error	**762**
Upper limit claims in error	1,051
Lower limit claims in error	473

Note: The upper and lower error limits represent the range of potential error (e.g. if 100 sample items were selected the rate of error would fall between these limits 95 times.)

It should be noted that all 46 errors (23 financial and 23 procedural) on the sampled claims reviewed by the examiner resulted from the inconsistent application of the definition of the term "Deductible", as contained in the Company's Certificate of Insurance and its Group Application Form.

The term "Deductible" is defined in the Certificate of Insurance booklet provided to the employers under HIC's group contracts. This booklet is to be distributed to each subscriber by the employer. The definition of Deductible contained in this booklet reads as follows:

> *"The term Deductible means the fixed amount which the Member must pay for Covered Services in a Calendar Year prior to the application of Coinsurance."*

The term "Deductible" was also defined in the Company's Group Application Form, which also serves as the Group Policy. It reads as follows:

> *"The term Deductible means the fixed amount which the Member must pay for Covered Services in a Calendar Year prior to the application of Coinsurance when using the Out-of-Network Option."*

The main difference in the above definitions of "Deductible" is that the Group Policy applies the definition of deductible to only out-of-network benefits; whereby the Certificate of Insurance applies the deductible to both in-network and out-of-network benefits. Therefore, an ambiguity exists between the Group Policy and the Certificate of Insurance. The examiner's review determined that HIC charged a deductible to all subscribers, regardless of whether the subscriber used a participating (in-network) or non-participating (out-of-network) provider.

Section 3221(a)(6) of the New York Insurance Law states in part:

> "The insurer shall issue either the employer or the person in whose name the policy is issued for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage…"

Because of the differences in the abovementioned two documents, Healthplex did not issue a certificate setting forth the essential features of the insurance coverage under the Group Policy, in violation of Section 3221(a)(6) of the New York Insurance Law.

It is recommended that Healthplex comply with the requirements of Section 3221(a)(6) of the New York Insurance Law and make the amendments necessary to bring consistency between the Group Application form and the Certificate of Insurance form.

Subsequent to the examination date, after consultation with the Department, Healthplex submitted a revised Group contract, which was approved by the Department on March 13, 2006, thereby making the document consistent with the Certificate of Insurance.

B. Prompt Pay Law

§3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims or the undisputed portion of the claim within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest shall be payable.

§ 3224-a(a) of the New York Insurance Law states in part:

> "Except in a case where the obligation of an insurer… to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

The Company appeared to be in compliance with the requirements of §3224-a of the New York Insurance Law. A review of HIC's claims revealed that none were paid more than forty-five days from the date of receipt.

C. Explanation of Benefits Statements

As part of the review of the Company's claims practices and procedures, an analysis of the explanation of benefits statements ("EOB") sent to subscribers and/or providers by the Company was performed. An EOB is an important link between the subscriber, the provider, and the Company. It should clearly communicate to the subscriber and/or provider that the Company has processed a claim and how that claim was processed. It should clearly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered, and show any balance owed to the provider. It should also serve as the documentation to recover any money from coordination of benefits with other carriers.

The sample selected for analyzing EOBs was the same as used for the claims processing review noted in 6A above.

§3234(b)(7) of the New York Insurance Law states in part:

> "(b) The explanation of benefits form must include at least the following:
>
> (7) …a description of the time limit, place and manner in which an appeal or a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

A review of the Company's EOBs determined that the statements did not contain the notification that failure to comply with the requirements of the Company's appeal process, may lead to forfeiture of the consumer's right to challenge a denial or rejection, even when a request for clarification has been made, as required by §3234(b)(7) of the New York Insurance Law.

It is recommended that the Company add a notification to its explanation of benefits statements that complies with the requirements of §3234(b)(7) of the New York Insurance Law.

In addition, during the review of the Company's EOBs, it was noted that the amount the insured was responsible for, as stated in the explanation of benefits statement was unclear. For example, there were amounts that were not payable to the provider due

to contractual arrangements between HIC and the provider, but it was not clear that the insured was not responsible for paying that amount.

§3234(b)(5) of the New York Insurance Law states:

> "(b) The explanation of benefits form must include at least the following:
>
> (5) The amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed."

It is recommended that the Company comply with the requirements of §3234(b)(5) of the New York Insurance Law by clearly stating the amount of the insured's responsibility.

D. Underwriting

§4235(k) of the New York Insurance Law states in part:

> "…Whenever any policy as described in this section terminates as a result of a default in payment of premiums, the insurer shall notify the policyholder that termination has occurred or will occur and shall include in his notification reference to the policyholder's responsibilities under section two hundred seventeen of the labor law."

Further, Section 55.2(a) of Department Regulation 78 (11 NYCRR 55) states:

> "(a) An insurer who intends to terminate a group policy or contract of accident, or health, or accident and health insurance issued to a policyholder, covering individuals who because of their employee status are certificateholders under a group policy shall give the policyholder at least 30 days prior written notice of its intent to terminate coverage. The notice to the policyholder shall set forth in detail the policyholder's obligation under Labor Law, section 217, and under this Part, to notify each certificateholder resident in New York State of the intended termination of the group policy."

It was noted that there was an instance where the Company's cancellation notice sent to a policyholder provided the policyholder with less than 30 days prior written notice of HIC's intent to terminate coverage. In addition, the standard cancellation notice provided by HIC did not provide the necessary information as required by §4235(k) of the New York Insurance Law.

It is recommended that HIC provide the policyholder with at least 30 days prior written notice of its intent to terminate coverage as required by Section 55.2(a) of Department Regulation 78 (11 NYCRR 55). Furthermore, it is recommended that HIC comply with §4235(k) of the New York Insurance Law and indicate the policyholder's obligations under Section 217 of the Labor Law.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. *22240*

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, *GREGORY V. SERIO* , Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Roy Zabala

as a proper person to examine into the affairs of the

Healthplex Insurance Company

and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this *29th* day of *July* *2004*

Gregory V. Serio
Superintendent of Insurance