REPORT ON EXAMINATION

OF THE

HEALTHPLEX INSURANCE COMPANY

AS OF

DECEMBER 31, 2009

DATE OF REPORT	**FEBRUARY 17, 2012**
EXAMINER	**EDOUARD MEDINA**

TABLE OF CONTENTS

February 17, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Number 30562, dated June 24, 2010, attached hereto, I have made an examination into the condition and affairs of Healthplex Insurance Company, an accident and health insurance company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, as of December 31, 2009, and respectfully submit the following report thereon.

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

Wherever the designations the "Company" or "HIC" appear herein, without qualification, they should be understood to indicate Healthplex Insurance Company.

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

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Insurance Department. On October 3, 2011, the New York State Insurance Department merged with the New York State Banking Department to become the New York State Department of Financial Services.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 2004. This examination was a combined (financial and market conduct) examination and covers the five-year period January 1, 2005 through December 31, 2009. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook*, 2009 Edition (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook and where deemed appropriate by the examiners, transactions occurring subsequent to December 31, 2009 were reviewed.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Company's operations and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007; thus, this was the first such type of examination of the Company. The examiners planned and performed the examination to evaluate the

Company's current financial condition, as well as identify prospective risks that may threaten the future solvency of HIC.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines, Statutory Accounting Principles, as adopted by the Department, and annual statement instructions.

Information concerning the Company's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Company's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Company was audited annually, for the years 2005 through 2009, by the accounting firm of Libero & Kappel, LLP ("LK"). The Company received an

unqualified opinion in each of those years. Certain audit workpapers of Libero & Kappel, LLP were reviewed and relied upon in conjunction with this examination.

The examiners reviewed the corrective actions taken by the Company with respect to the recommendations contained in the prior report on examination. The results of the examiner's review are contained in Item 6 of this report.

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 an explanation or description.

2. DESCRIPTION OF THE 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.

Healthplex Insurance Company offers dental contracts to groups 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) or 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, 2009, were as follows:

Name and Residence	Principal Business Affiliation
Dr. Michael Carnicelli St. Augustine, FL	Retired
Karen Cuchel Brooklyn, NY	Retired
Dr. Stephen Joseph Cuchel Roslyn Harbor, NY	Chairman and Co-CEO Healthplex, Inc.
Stuart W. Fenton Beachwood, OH	Vice President, ING Funds Distributor, LLC
Dr. George Kane Southampton, NY	Vice President and Treasurer, Healthplex, Inc.
Martha Kane Hewlett Harbor, NY	Retired
Dr. Martin Kane Hewlett Harbor, NY	President, Healthplex, Inc.
Dr. Stephan 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.

Name and Residence	Principal Business Affiliation
Dr. Bruce Henry Safran Manhasset, NY	Vice President, Healthplex, Inc.
George Wang New York, NY	Attorney, Thelen, Reid & Priest LLP.
Valerie Vignola Bellmore, NY	Chief Financial Officer Healthplex, Inc.

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 four times per calendar year during the period January 1, 2005 through December 31, 2009. A review of the minutes of the Board of Directors' meetings indicated that meetings were generally well attended, with all members attending at least one-half of the meetings they were eligible to attend.

Although HIC's Board traditionally meets four times a year, the by-laws do not require the Board to meet at least four times a year, as recommended by the prior examination report. Infrequent meetings could result in the Board not being able to fulfill its fiduciary duty and provide adequate oversight of the operations of the Company. The Company should revise its by-laws to require that the Board 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, 2009 were as follows:

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

Note: Dr. Bruce Henry Safran retired from the Company and from the Board in June 2010. He was replaced by Valerie Vignola during the same month. She is now a Board member as well as the Secretary of the Company.

Members of the Board have a responsibility and must evince an ongoing interest in the affairs of the insurer. Section 1411(a) of New York Insurance Law requires that Board members be informed of and authorize the Company's investments.

Section 1411(a) of the New York Insurance Law states in part:

> "No domestic insurer shall make any loan or investment… unless authorized or approved by its board of directors…"

Upon review of the minutes of the Board of Directors' meetings, it was noted that the minutes did not contain information, on a consistent basis, regarding the approval of the Company's investments its Board.

It is recommended that the Company complies with the requirements of Section 1411(a) of the New York Insurance Law by having the Board authorize all of its investments.

Furthermore, it was noted that the Company did not have a written investment guideline/policy. Although the Company's investments as of the examination date,

consisted mainly of short-term U.S. Treasury Bonds, the Company should develop, as a prudent business practice, an investment guideline/ policy authorized by its Board.

It is recommended that the Company adopt and abide by formal written investment guidelines.

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.

Upon licensing, HIC committed to taking or causing to be taken, steps as may from time to time be necessary, including limiting its new business writings, to produce a premium-to-surplus ratio of not more than 4:1.

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

Calendar Year	Direct Premiums Written	Enrollment
2005	$ 944,265	2,396
2006	$ 953,210	2,401
2007	$ 961,436	2,574
2008	$ 954,255	2,544
2009	$ 892,100	2,289

The following compares the Company's "Actual" amounts for DPW for the last three years of operation, covered by the examination, versus the Company's "Projected" amounts as shown in its Business Plan submitted to the Department:

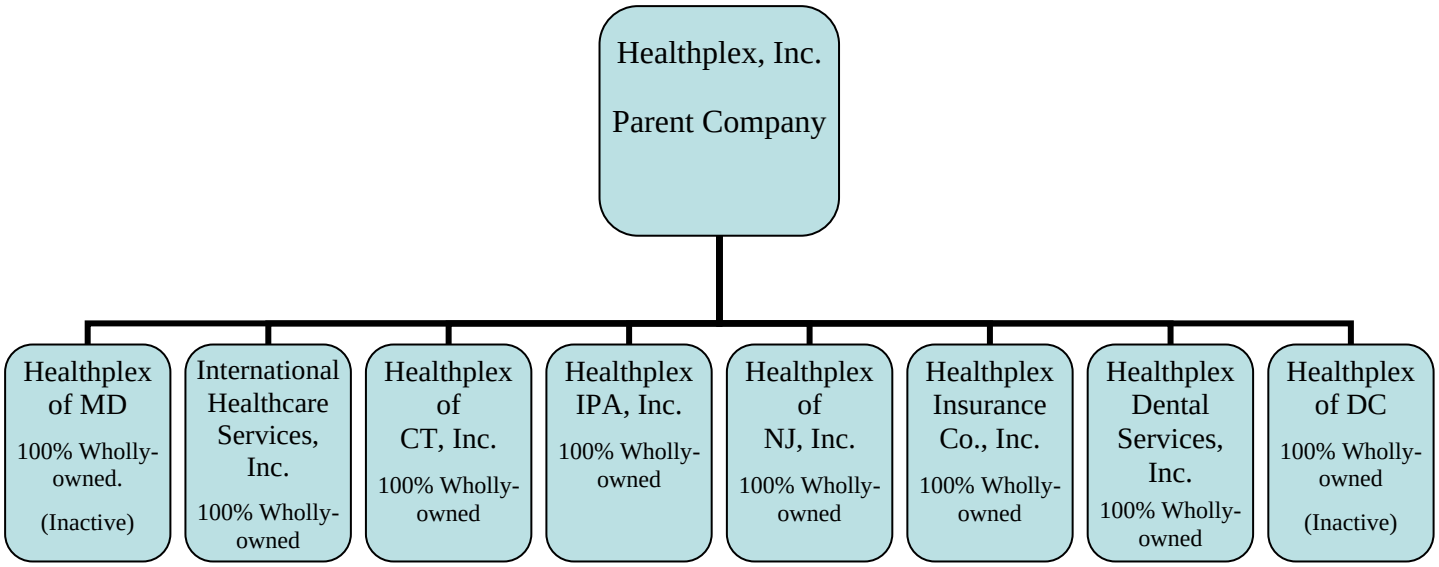
Year	Projected DPW	Actual DPW	Variance
2007	$ 983,571	$ 961,436	$ (22,135)
2008	$ 1,032,749	$ 954,255	$ (78,494)
2009	$ 1,084,386	$ 892,100	$ (192,286)

As denoted in the above chart, the Company did not meet its projected premium writings. As per the Company's 2009 Management Discussion and Analysis, this was due to the Company experiencing member attrition as a result of the recessionary economy of the past few years. The risk of the Company, not being able to grow its business and meet its projected premium, is a cause for concern.

C. Holding Company System

Healthplex Insurance Company is a wholly-owned subsidiary of Healthplex, Inc., a privately traded 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 No. 52 (11 NYCRR 80). The Company made all of 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 was effective as 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 issued an amendment to the above services agreement dated and executed on March 1, 2008. According to the amendment, any discounted settlements or forgivenesses of debt, regarding the financial obligations of the Company to Healthplex Inc., will be subject to the Department's prior notice, or prior approval pursuant to Section 1505 of the New York Insurance Law. The amendment was submitted to the Department on November 1, 2006, pursuant to Section 1505(d)(3) of the New York Insurance Law. The Department did not issue an approval of the amendment.

On April 18, 2011, subsequent to the examination period, the Company submitted a second amendment to their Administrative Services Agreement. The amendment was approved by the Department on April 26, 2011.

A review of the services agreement was conducted by the examiners to ascertain if the Parent was rendering the services in accordance with the terms of the agreement. The Company was asked to provide proof that the Parent was issuing the "Monthly Personnel and Computer Services Report" as specified in Exhibit 1 of the agreement. It was determined that the Company instead maintained this information on an annual basis, stating that, based upon the amount of business produced, they felt that an annual report would be more efficient than the monthly one.

It is recommended that the Company complies with the terms of its services agreement.

The Company also entered into a consolidated Tax Allocation Agreement, with its Parent, with an effective date of March 29, 1999. 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. However, the Company elected to be treated as an S Corporation, effective January 1, 2005; accordingly, no provision for federal taxes is made.

A review of the Company's holding company transactions that occurred during the examination period revealed that the Company completed certain transactions in 2009

in violation of various Department statutes and Regulations. These are detailed as follows:

1. The amount allocated for outsourced services in the annual statement includes $44,605, which is five percent of the annual premiums for the Company ($892,100). There was no support for the $44,605. The basis the Company used is the total premium. This procedure is not consistent with the provisions of Part 109.3(d) of Department Regulation No. 30 (11 NYCRR 109.3(d)).

Part 109.3(d) of Department Regulation No. 30 (11 NYCRR 109.3(d)) states in part:

> "(d) Premiums. (1) Premiums shall not be used as a basis of allocation except when specifically noted as a permissible basis or when the expense is incurred as a percentage of premiums (subject to instructions under commission and allowances in § 107.3(c)(2)), or when the expenses are logically allocable on the basis of premiums. In no event shall premiums be used as a basis of allocation in connection with clerical, technical, secretarial, office maintenance, supervisory and executive activities unless such basis is clearly appropriate and until all other reasonable basis of allocations have been considered and found less appropriate than premiums…"

Additionally, Exhibit I of the Company's Administrative Services Agreement specifies how fees for outsourced services provided by the Parent to the Company are to be paid.

Exhibit I of the Company's Administrative Services Agreement states in part:

> *"The plan on a monthly basis, shall pay to Healthplex, fees for the following services on a cost basis, but not greater than the plan would expend in providing such services for itself.*
>
> *For personnel assigned to data entry, claims processing, customer service, marketing and clerical responsibilities, a sum equal to the employees*

> *salaries, prorated to the actual hours worked on Healthplex Insurance Company business…*
>
> *For computer services, a sum equal to the actual costs of he computer time used for inputting and processing information, plus the costs of computer storage for the data required to be on-line and accessible. Charges will not be made for standard utilization reports..."*

It is recommended that the Company complies with its Administrative Services Agreement and with Department Regulation No. 30 by paying fees for outsourced services, provided to the Company by its Parent, in accordance with its Administrative Services Agreement and Department Regulation No. 30.

2. The Company disbursed $16,889 as payments to the Superintendent of Insurance, NAIC, and SunGard. This amount included a $2,075 payment to SunGard for its software disaster recovery services. This amount represents twenty-one percent of the SunGard invoice total ($9,875) to the Parent. The Company was unable to determine what basis was used to allocate this amount to HIC. This is a violation of Part 106.6(b) of Department Regulation No. 30 (11 NYCRR 106.6(b)).

   Part 106.6(b) of Department Regulation No. 30 (11 NYCRR 106.6(b)) states:

   > "(b) The effects of the application, to each operating expense classification of all bases of allocation shall be shown on records kept in clear and legible form. Such records shall be readily available for examination."

   It is recommended that the allocation of expenses between the Company and the Parent be apportioned in conformity with the provisions of Part 106.6(b) of Department Regulation No. 30.

Furthermore, the abovementioned transactions and allocations are in violation of Sections 1505(a) and (b) of the New York Insurance Law, which state:

> "(a) Transactions within a holding company system to which a controlled insurer is a party shall be subject to the following: (1) the terms shall be fair and equitable; (2) charges or fees for services performed shall be reasonable; and (3) expenses incurred and payments received shall be allocated to the insurer on an equitable basis in conformity with customary insurance accounting practices consistently applied.
>
> (b) 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."

It is recommended that the Company complies with the requirements of Sections 1505(a) and (b) of the New York Insurance Law and establish an allocation procedure that defines how the expenses are to be allocated.

D. Significant Operating Ratios

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

	Amounts	Ratios
Claims incurred	$ 2,600,079	55.26%
Claims adjustment expenses incurred	38,022	.81%
General administrative expenses incurred	1,589,682	33.78%
Net underwriting gain	477,483	10.15%
Premiums earned	$ 4,705,266	100.00%

E. Reinsurance

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

F. Custodial Agreement

As of the examination date, the Company's securities were held with the Bank of America, pursuant to a custodial agreement. The Department requires that custodial agreements contain certain provisions in order to ensure that insurers' assets are properly safeguarded. A review of the Company's custodial agreement indicated that it was lacking the following protective covenants:

1. The bank shall have in force, for its own protection, Bankers Blanket Bond Insurance of the broadest form available for commercial banks and will continue to maintain such insurance. The bank will give the Company 60 days written notice of any material change in the form or amount of such insurance or termination of this coverage.

2. The bank will at all times give the securities held by the bank the same care the bank gives its own property of a similar nature.

3. Furnish the Company (at least quarterly) with a list of such securities showing a complete description of each issue, which shall include the number of shares or par value of bonds so held at the end of such quarter.

4. Maintain records sufficient to verify information the Company is required to report in the Annual Statement blank of the Insurance Department of the State of New York.

5. The bank shall furnish the Company with the appropriate affidavits in an acceptable form in order for the securities referred to in such affidavits to be recognized as admitted assets of the Company.

6. Access shall be during the bank regular hours. Those persons who shall be entitled to examine, on the bank premises, securities held by the bank and the bank records related to those securities, shall be specified. An authorized officer shall furnish the bank with written instructions to that effect.

7. Written instructions hereunder shall be signed by any two of the Company authorized officers specified in a separate list for this purpose which will be furnished to the bank from time to time signed by an officer and certified under the corporate seal by an officer.

8. In connection with any situation involving registration of securities in the name of a nominee of a bank custodian, the custodian agreement should empower the bank to take such action.

9. There should be a provision in the agreement that would give the Company the opportunity to secure the most recent report on the review of the custodian system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors.

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

Subsequent to the examination date, the Bank of America agreed to incorporate the above protective covenants into a document called "the Amendment to Custody Agreement" that became effective on August 17, 2010. This document is attached to the custodial agreement between the Company and the Bank of America.

G. Conflict of Interest Statements

A review of the Company's Code of Ethics and Conflict of Interest Statements that are required to be prepared by the Company's Board members, officers and key employees revealed that only three directors fully complied with the conflict of interest statement requirements. The other ten directors did not comply with the conflict of interest statement instructions. They failed to check off the appropriate boxes on the statement forms. This process was overseen by the Company's Secretary.

It is not sufficient merely to adopt a conflict of interest program, since to be effective and to avert occurrences of conflict, the Company must ensure compliance with the established program.

It is recommended that, as a prudent business practice, the Company follow its formal conflict of interest reporting procedures relative to its directors, officers and key employees.

H. Accounts and Records

During the course of the examination, it was noted that the Company's treatment of certain items was not in accordance with Department Regulations, New York Insurance Law, and/or annual statement instructions. A description of such items is as follows:

1. During the examination of net premium income, the examiner reviewed some policies to ascertain the accuracy of the premiums charged to the groups and the premium income reported in the annual statement. The Company was unable to provide the coverage application for one of the groups. This is a violation of Part 243.2(b) of Department Regulation No. 152 (11 NYCRR 243.2(b)).

   Part 243.2(b) of Department Regulation No. 152 (11 NYCRR 243.2(b)) states:

   > "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
   >
   > (1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this Part A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to Section 243.3(a) of this Part."

It is recommended that the Company complies with Part 243.2(b) of Department Regulation No. 152 by keeping records of all coverage applications for the required period.

2. A review of the Company's insurance application forms and member enrollment cards was conducted. It was noted that the Company did not seek the Department's approval for its insurance application forms or its members' enrollment cards. This is a violation of Section 3201(b)(1) of the New York Insurance Law.

   Section 3201(b)(1) states in part:

   > "(b)(1) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law…"

   It is recommended that the Company complies with the requirements of Section 3201(b)(1) of the New York Insurance Law by seeking the Department's approval for its insurance application forms and its members' enrollment cards.

3. A review of the Company's Scheduled DA – Part 1 – Short-Term Investments Owned December 31 of Current Year revealed that the Company reported the same security amounts for its book adjusted carrying value, par value, and actual cost. Failure to properly report this information in the annual statement obscures the accuracy of the annual statement. This practice is not in accordance with the 2009 NAIC annual statement instructions which defines the book/adjusted carrying value, par value, and actual cost as follows:

> *"Book/adjusted carrying value is the amortized value or the lower of amortized value or fair value, as appropriate (and adjusted for any other than temporary impairment), as of the end of the current reporting year; Par value is the par value of the bonds owned adjusted for repayment of principal; Actual cost includes cost of acquiring the issue, including brokers' commission and incidental expenses of effecting delivery."*

It is recommended that the Company report its short-term investments' book/adjusted carrying value, par value, and actual cost as indicated by the NAIC annual statement instructions.

4. A review of the Company's Schedule DA - Part 1 - Short-Term Investments Owned December 31 of Current Year revealed that the Company treated and reported its long-term money market mutual fund as a short-term investment. The fund was acquired on April 18, 2001 with a maturity date of December 31, 2010. This practice is not in compliance with Paragraph 10 of Statement of Statutory Accounting Principles (SSAP) No. 2.

   Paragraph 10 of SSAP No. 2 states:

   > "All investments with remaining maturities (or repurchase dates under repurchase agreements) of one year or less at the time of acquisition (excluding those investments classified as cash equivalents as defined in paragraph 3 shall be considered short-term investments."

   Although there was no valuation difference in the Company's assets, by incorrectly filing its money market mutual fund as a short-term investment, the Company incorrectly overstated its short-term investments and understated its long-term investments in its filed 2009 annual statement.

It is recommended that the Company complies with Paragraph 10 of SSAP No. 2 by treating and reporting as short-term investments only securities with remaining maturities of one year or less at the time of acquisition.

It is also recommended that the Company exercise greater care when preparing Schedule DA of its annual statement.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following shows the assets, liabilities, and surplus as determined by this examination as of December 31, 2009. This is the same as the balance sheet filed by the Company in its December 31, 2009 annual statement:

Assets	Examination	Company
Cash and short term investments	$ 1,025,395	$ 1,025,395
Investment income due and accrued	257	257
Uncollected premiums and agents' balances in the course of collection	1,147	1,147
Total assets	$ 1,026,799	$ 1,026,799
Liabilities		
Claims unpaid	$ 40,045	$ 40,045
Unpaid claims adjustment expenses	647	647
Premiums received in advance	13,850	13,850
Amounts due to parent, subsidiaries and affiliates	24,847	24,847
Total liabilities	$ 79,389	$ 79,389
Capital and Surplus		
Common capital stock	$ 300,000	$ 300,000
Gross paid-in and contributed surplus	209,500	209,500
Unassigned funds (surplus)	437,910	437,910
Total capital and surplus	$ 947,410	$ 947,410
Total liabilities, capital and surplus	$ 1,026,799	$ 1,026,799

Note: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Company through tax year 2009. 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. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased by $555,323, during the five-year examination period January 1, 2005 through December 31, 2009, detailed as follows:

Revenue		
Premium earned	$ 4,705,266	
Net investment gain	77,841	
Total revenue		$ 4,783,107
Expenses		
Other professional services	$ 2,600,079	
General administrative expenses	1,589,683	
Administrative claims adjustment expenses	38,022	
Total expenses		$ 4,227,784
Net income		$ 555,323

Changes in Capital and Surplus

Capital and surplus, per report on examination, as of December 31, 2004			$ 392,087
	Gains in Surplus	Losses in Surplus	
Net income	$ 555,323		
Net increase in capital and surplus			$ 555,323
Capital and surplus, per report on examination, as of December 31, 2009			$ 947,410

4. CLAIMS UNPAID

The examination liability of $40,045 is the same as that reported by the Company in its filed annual statement as of December 31, 2009.

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. The examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Company's experience in projecting the ultimate cost of claims incurred on or prior to December 31, 2009.

It should be noted that actuarial standards of practice require companies to incorporate in the development of claim reserves, a provision for margin for adverse claims fluctuations. Such a provision varies by company, but is typically around 10%. The Company failed to incorporate a margin for adverse claims fluctuations in its claims unpaid liability.

It is recommended that the Company incorporate a margin for adverse claims fluctuations in its claims unpaid liability.

5. MARKET CONDUCT ACTIVITIES

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 examination. The review was directed at the practices of the Company in the following major areas:

A. Agents and brokers
B. Claims processing
C. Prompt Pay Law
D. Explanation of benefits statements
E. Utilization review
F. Underwriting

A. Agents and Brokers

A review was performed of the Company's sales distribution system. For the period under review, the Company provided a listing of 114 producers. It was noted that the following practices were not in compliance with Article 21 of the New York Insurance Law:

1. Certificate of Appointment - Certificates of appointment for each of the agents selected for review was requested from Healthplex Insurance Company. It was noted that the Company did not issue a certificate of appointment to any of its agents. This is a violation of Section 2112(a) of the New York State Insurance Law.

Section 2112(a) of the New York State Insurance Law states:

> "(a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

It is recommended that the Company ensure that certificates of appointment are issued to its agents and filed with the Department, as required by Section 2112(a) of the New York Insurance Law.

2. Termination of Agents and Brokers - The Company does not terminate agents unless they are deceased. Section 2112(c) of the New York Insurance Law dictates that the Company terminate agents for either probable cause, or if the agent's license has been suspended or revoked by the Department or if the license has expired and was not renewed. Furthermore, the Company should include in its agency contracts, any additional provisions that would trigger the termination of an agent.

Section 2112(c) of the New York Insurance Law states:

> "(c) Certificates of appointment shall be valid until (i) terminated by the appointing insurer after a termination in accordance with the provisions of the agency contract; (ii) the license is suspended or revoked by the superintendent; or (iii) the license expires and is not renewed."

It is recommended that the Company complies with the requirements of Section 2112(c) of the New York Insurance Law and terminate agents in accordance with said statute.

3. Commissions Schedule - The violated Section 4235(h)(1) of the New York Insurance Law when it did not file with the Department the commissions schedule it used to pay its agents.

Section 4235(h)(1) of the New York Insurance Law states:

> "(h)(1) Each domestic insurer and each foreign or alien insurer doing business in this state shall file with the superintendent its schedules of premium rates, rules and classification of risks for use in connection with the issuance of its policies of group accident, group health or group accident and health insurance, and of its rates of commissions, compensation or other fees or allowances to agents and brokers pertaining to the solicitation or sale of such insurance and of such fees or allowances, exclusive of amounts payable to persons who are in the regular employ of the insurer, other than as agent or broker to any individuals, firms or corporations pertaining to such class of business, whether transacted within or without the state."

It is recommended that the Company complies with the requirements of Section 4235(h)(1) of the New York Insurance Law and file its commissions rate schedule with the Department.

B. 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, 2009 through December 31, 2009, in order to evaluate the overall accuracy and compliance environment of its claims processing. The examiner selected a sample of 50 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 the purposes 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, 2009 through December 31, 2009, as included in its annual statement filed with the Department.

The examination review revealed that the overall claims processing financial accuracy level was 98% and the overall claims processing procedural accuracy level was also 98%. 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 50 claims reviewed, there were two (2) procedural errors and one (1) financial error.

C. Prompt Pay Law

Section 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 a claim within forty-five days of receipt. If such undisputed claims are not paid within forty-five days (or thirty days for electronic claims) of receipt, interest may be payable.

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

> "(a) 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."

A review of HIC's claims revealed that none of the claims were paid more than forty-five days (or thirty days in the case of electronic claims) or denied more than thirty days from the date of receipt.

D. 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 among 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.

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

> "(b) The explanation of benefits form must include at least the following:
>
> (1) the name of the provider of service the admission or financial control number, if applicable;
>
> (2) the date of service;
>
> (3) an identification of the service for which the claim is made;
>
> (4) the provider's charge or rate;
>
> (5) the amount or percentage payable under the policy or certificate after deductibles, co-payments, and any other reduction of the amount claimed;
>
> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
>
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of 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."

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

Upon review of the Company's EOBs, it was determined that the EOBs did not contain information that complied with the requirements of Section 3234(b)(5) of the New York Insurance Law.

Additionally, the description of the time limit, place and manner in which an appeal of a denial of benefits must be brought was provided in a separate document labeled "Your Right to Appeal". The appeal right document and the EOBs are two different documents and there is no reference of the appeal right document made in the EOB. Therefore, if the Company fails to accompany the EOB with the appeal right document the members would not be able to tell that the appeal rights document is missing. This information is a violation of the requirements of Section 3234(b)(7) of the New York Insurance Law.

It is recommended that the Company complies with the requirements of Sections 3234(b)(5) and (b)(7) of the New York Insurance Law by incorporating in its EOBs all of the provisions outlined in the aforementioned statutes.

E. Utilization Review

The examiners conducted a review of the Company's utilization review procedures and processes to ascertain its compliance with Article 49 of the New York Insurance Law. The following violations were noted:

1. Section 4903(e) of the New York Insurance Law states:

> "(e) Notice of an adverse determination made by a utilization review agent shall be in writing and must include:
>
> (1) the reasons for the determination including the clinical rationale, if any;
>
> (2) instructions on how to initiate standard appeals and expedited appeals pursuant to section four thousand nine hundred four and an external appeal pursuant to section four thousand nine hundred fourteen of this article; and
>
> (3) notice of the availability, upon request of the insured's, or the insureds designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any, additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal."

The Company violated Section 4903(e) of the New York Insurance Law when it failed to incorporate appeal rights that it provided to its insureds into the adverse determination letter.

Furthermore, the Company's adverse determination letter did not include instructions on how to initiate an expedited appeal or external appeal. This is also a violation of Section 4903(e) of the New York Insurance Law.

It is recommended that the Company complies with the requirements of Section 4903(e) of the New York Insurance Law and incorporate its appeal rights into its adverse determination letter.

It is also recommended that the Company's adverse determination letter include instructions on how to initiate an expedited appeal or external appeal as required by Section 4903(e)(2) of the New York Insurance Law.

2. Section 4903(d) of the New York Insurance Law states:

> "(d) A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information."

Item 5, Retrospective Review, of the Company's Utilization Review Policy and Procedure (UM 7.1) states that "reviews are made and notification provided within 14 days, but in no event later than 44 days after receipt." This policy in not compliant with Section 4903(d) of the New York Insurance Law, which states that notification is to be delivered within 30 days of receipt of all the necessary information.

It is recommended that the Company complies with the requirements of Section 4903(d) of the New York Insurance Law and provide the retrospective review notification no later than 30 days after receipt of all necessary information.

3. Section 4903(c) of the New York Insurance Law states:

> "(c) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday."

Item 4, Concurrent Review, of the Company's Utilization Review Policy and Procedure (UM 7.1) states that reviews are made and notification provided within 1

business day, but in no event later than 14 days after receipt. This policy is not compliant with Section 4903(c) of the New York Insurance Law.

It is recommended that the Company amend Section UM 7.1 of its Utilization Review Policy and Procedure, with regard to its concurrent review notification, so that it is in compliance with the requirements of Section 4903(c) of the New York Insurance Law.

4. Section 4903(b) of the New York Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

Item 3, Prospective Review, of the Company's Utilization Review Policy and Procedure (UM 7.1) states that reviews are made and notification provided within 1 business day, but in no event later than 14 days of receipt. This policy is not compliant with Section 4903(b) of the New York Insurance Law.

It is recommended that the Company complies with the requirements of Section 4903(b) of the New York Insurance Law and provide the prospective review notification within the required number of days as stated in the statute.

5. In the Exhibit of Grievances and Utilization Review Appeals - Accident & Health Insurance Contracts: New York State Business, Part Two of its Supplement to the Health Blank Annual Statement, the Company reported thirty-four cases of Utilization Review

Appeals in column two. During our review of the captioned account the Company stated that they did not have any utilization review appeals during calendar year 2009 and that the thirty-four cases reported in the above exhibit belonged to other companies in its holding company group.

It is recommended that the Company complies with the requirements of Section 307(a)(1) of the New York Insurance Law by exercising greater care when filing Exhibit of Grievances and Utilization Review Appeals - Accident & Health Insurance Contracts: New York State Business, Part Two of its Supplement, to the Health Blank Annual Statement.

F. Underwriting

A review of the Company's underwriting practices revealed the following violations of Department Regulations and the New York Insurance Law:

1. Part 55.2(a) of Department Regulation No. 78 (11 NYCRR 55.2(a)) 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 certificate holders 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 certificate holder resident in New York State of the intended termination of the group policy."

The Company violated the above Regulation when it failed to provide the policyholder with at least 30 days notice of its intent to terminate. The Company only provided the policyholder with a 10-day notice of its intention to terminate coverage.

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 Part 55.2(a) of Department Regulation No. 78.

2. Part 243.2(b)(1) of Department Regulation No. 152 (11 NYCRR 243.2(b)(1)) states in part:

> "(1) A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this Part A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to Section 243.3(a) of this Part…"

The Company was unable to provide copies of termination letters sent to groups. The Company instead submitted a standard letter and a printout containing the name of the group and a date as a proof that a letter went out to this particular group on such a date. If a member later seeks proof that a termination letter was indeed sent out, the Company would not be able to provide the original letter.

It is recommended that the Company complies with the requirements of Part 243.2(b)(1) of Department Regulation No. 152 by keeping records of all notices that were issued to insureds, for the required amount of time as specified in the Regulation.

3. Section 2601(a)(4) of the New York Insurance Law states in part:

> "(a) No insurer doing business in this state shall engage in unfair claim settlement practices. Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claim settlement practices…

> (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear…"

Once a group is delinquent in paying its premium, the Company's computer system will change the status of the group to "active delinquent". This status prevents any claims, regardless of if the claim was for services provided during a non-delinquent month, from being paid or processed for this group. For example if a member company's premium was not paid for the month of December, but had been paid for October and November, the status of the member company would become "active delinquent" for December, however, claims submitted by the member company, during this period, for services performed in October or November would not be paid by the Company. This may lead to the Company not processing claims for services rendered during a period for which premiums were already paid.

It was determined that such practice as described above constitutes an unfair claims settlement practice as defined by Section 2601(a)(4) of the New York insurance Law.

It is recommended that the Company avoids potential violations of Section 2601(a)(4) of the New York Insurance Law by revising its termination procedures to allow the processing of claims issued for services rendered during the periods for which premiums were already paid.

Additionally, although the Company has never been fined for violations of the Prompt Pay Law Section 3234-a(a) of the New York Insurance Law, such practices could also lead to such violations.

6. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination as of December 31, 2004, contained the following twenty (20) comments and recommendations pertaining to the financial portion of the examination (page number refers to the prior report on examination):

ITEM NO.		PAGE NO.
	Description of the Company	
1.	It is recommended that the Company include the correct date of its incorporation on the Jurat Page of its filings with this Department.	3
	The Company has complied with this recommendation.	
	Management and Controls	
2.	It is recommended that the Company amend its by-laws to require its Board to meet a minimum of four times per calendar year.	5
	The Company has not complied with this recommendation. A similar comment is contained in this report.	
3.	It is recommended that the Company adopt and abide by formal written investment guidelines for all future investments.	6
	The Company has not complied with this recommendation. A similar comment is contained in this report.	
4.	It is recommended that the Company amend and file its Business Plan with the 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.	7
	The Company has complied with this recommendation.	
	Holding Company System	
5.	It is recommended that the Company comply with the requirements of Section 1505(c) of the New York Insurance Law.	10
	The Company has complied with this recommendation.	

ITEM NO.		PAGE NO.
	Holding Company System (Cont'd)	
6.	It is recommended that the Company comply with the requirements of Section 1505(b) of the New York Insurance Law. *The Company has complied with this recommendation.*	11
7.	It is recommended that the Company comply with the requirements of SSAP No. 25. *The Company has complied with this recommendation.*	12
8.	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. *The Company has not complied with this recommendation. A similar comment is contained in this report.*	12
9.	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. *The Company has complied with this recommendation.*	13
10.	It is recommended that the Company properly record all capital contributions in its financial statements filed with this Department. *The Company has complied with this recommendation.*	13
	Accounts and Records	
11.	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. *The Company has complied with this recommendation.*	14
12.	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. *The Company has complied with this recommendation.*	15

ITEM NO. **PAGE NO.**

Accounts and Records (Cont'd)

12. 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. 15

The Company has complied with this recommendation.

13. It is recommended that the Company amend its custodial agreement to include the required provision in order to provide its assets with the necessary safeguards. 16

The Company has not complied with this recommendation. A similar comment is contained in this report.

14. 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. 16

The Company has complied with this recommendation.

15. 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. 17

The Company has not complied with this recommendation. A similar comment is contained in this report.

Unpaid Claims Adjustment Expenses

16 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. 20

The Company has complied with this recommendation.

Claims Processing

17. 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. 25

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.

The Company has complied with this recommendation.

ITEM NO. **PAGE NO.**

Explanation of Benefits Statements

18. 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. 27

The Company has not complied with this recommendation. A similar comment is contained in this report.

19. 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. 28

The Company has complied with this recommendation.

Underwriting

20. 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. 29

The Company has not complied with this recommendation. A similar comment is contained in this report.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Appointment No. **30562**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Edouard Medina

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 condition of the said

Company

with such other information as he shall deem requisite.

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

this 24th day of June, 2010

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR