REPORT ON EXAMINATION

OF THE

EASTERN VISION SERVICE PLAN, INC.

AS OF

DECEMBER 31, 2004

DATE OF REPORT AUGUST 30, 2006

EXAMINER BARBARA FINNERTY

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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 of Insurance

August 30, 2006

Honorable Howard Mills
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and in compliance with the instructions contained in Appointment Number 22433, dated March 20, 2006, annexed hereto, I have made an examination into the condition and affairs of Eastern Vision Service Plan, Inc., an Article 43 of the New York Insurance Law insurer as of December 31, 2004 and submit the following report thereon.

The examination was conducted at the Plan's office located at 3333 Quality Drive, Rancho Cordova, CA 95670. Eastern Vision Service Plan, Inc. is a wholly owned subsidiary of Vision Service Plan, Inc.

Wherever the designations "the Plan" or "EVSP" appears herein without qualification, it should be understood to indicate Eastern Vision Service Plan, Inc. Whenever the terms "the Parent" or "VSP" appear herein without qualification, they should be understood to mean Vision Service Plan, Inc.

1. SCOPE OF EXAMINATION

The previous examination was conducted as of December 31, 1999. This examination covered the period from January 1, 2000 through December 31, 2004. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner.

The examination comprised a risk based verification of assets and liabilities as of December 31, 2004 in accordance with statutory accounting principles (SAP), as adopted by this Department, a review of income and disbursements deemed necessary to accomplish such verification and utilized, to the extent considered appropriate, work performed by the Plan'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:

History of the Plan
Management and control
Corporate records
Fidelity bonds and other insurance
Territory and plan of operation
Growth of the Plan
Business in force
Accounts and records
Loss experience
Financial statements
Treatment of policyholders and claimants

A review was also made to ascertain what action was taken by the Plan with regard to comments and recommendations in the prior report on examination.

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

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies, including deficiencies related to the board governance of the Plan during the examination period. The most significant findings of this examination include the following:

- The Plan had issued subscriber contracts to administer the vision benefits provided to HMO clients that constituted its reported risk revenue business. The Plan defined an HMO to be a group for purpose of insurance under subscriber contracts in violation of New York Insurance Law Section 4235(c).

- Although the Plan did form an IPA, Eastern Vision Service IPA, Inc. (EVSIPA), no business has been transacted through the IPA. Therefore, the Plan violated New York State Department of Health Regulation Part 98 by retaining the capitation relative to its risk revenue business for its own account.

- The Plan disclosed Administrative Service Contract (ASC) plan transactions in accordance with the disclosure requirements for an Administrative Service Only (ASO) plan, except for the claim volume disclosure requirement. The disclosure requirements for an ASO plan differ from those of an ASC plan.

- The Plan reported the fee-for-service amounts associated with the administrative service contracts within the net reimbursements for

administrative expenses over actual expenses. The uncovered benefits were not segregated from the ASC revenue and medical premiums and expenses in accordance with the instructions for Fee-for-Service found within the NAIC 2004 Annual Statement Instructions – Health, Statement of Revenue and Expenses.

- The Plan used affiliated labs and used a composite rate to reimburse the affiliated labs for services performed. The composite rate includes a profit margin which was paid to other members of the Plan's holding company in violation of Section 1505(a)(1) of the New York Insurance Law.

- Routine services performed on behalf of the Plan are subject to prior notification under Section 1505(d)(3) of the New York Insurance Law.

3. DESCRIPTION OF THE PLAN

Eastern Vision Service Plan, Inc. was incorporated on August 29, 1985 and licensed by this Department on June 1, 1987 as a not-for-profit medical expense indemnity corporation pursuant to the provisions of Article 43 of the New York Insurance Law. The Plan began business in 1987.

The Plan was formed by the California Vision Service Plan, later renamed Vision Service Plan, Inc. ("VSP"), a California not-for-profit corporation. The Plan was formed as a non-profit medical expense indemnity corporation for the purpose of providing its subscribers and their families with vision care on a prepaid or fee-for-service basis. The Plan is affiliated with a network of 15 member vision service corporations nationwide.

The Plan maintains its books of account and corporate records at the office of its parent at 3333 Quality Drive, Rancho Cordova, California. The Plan has obtained

regulatory approval for this arrangement pursuant to New York Insurance Law §325(b).

An office located in Parsippany, New Jersey handles the sales and servicing for New York groups. Claim forms for the Plan are processed and stored in the Parent's headquarters in Rancho Cordova, CA.

All of the board of directors' meetings was held in New York.

A. Management

Pursuant to the Plan's charter and by-laws, management of the Plan is vested in a board of directors consisting of four members. The board meets once during each calendar year. The directors as of December 31, 2004 were as follows:

Name and Residence	**Principal Business Affiliation**
Provider	
David Dexter, O.D. Oswego, New York	Optometrist, Private Practice
Subscriber	
Richard A. Matlaga New York, NY	Director of Finance, The Carnegie Hall Corporation
Officer-Employee	
Walter E. Grubb Fair Oaks, California	Vice-President, Vision Service Plan, Inc.
Public	
Gabrielle Schang New York, NY	Director, Marketing and Special Projects, Children's Hospital at Montefiore

The minutes of all meetings of the Board of Directors' and committees thereto held during the examination period were reviewed.

It is recommended that the Board of Directors meet quarterly at a minimum to review the quarterly financial condition of the Plan and evince fiduciary oversight.

The following were the principal officers of the Plan on December 31, 2004:

Name	Title
Roger J. Valine	President
Patricia Cochran	Treasurer
Gary N. Brooks	Secretary

B. Territory and Plan of Operation

The Plan is licensed to do the business of a not-for-profit medical expense indemnity corporation pursuant to the provisions of Article 43 of the New York Insurance Law and is authorized to conduct its operations in all counties of the State of New York. The Plan's sole line of business during the examination period was vision services.

Services are provided through a network of participating optometrists and ophthalmologists who accept the Plan's schedule of fees as full payment for covered services. Subscribers may also secure services from non-member doctors who are reimbursed pursuant to a non-participant doctor reimbursement schedule.

The following schedule shows growth in enrollment for the period from January 1, 2000 through December 31, 2004:

Year End	Membership	Enrollment Increase/(Decrease)
2000	1,058,033	
2001	1,086,393	3.0%
2002	1,066,790	(2.0%)
2003	1,071,276	(0.4%)
2004	426,666	(60.0%)

The drop in enrollment was due to a change in the methodology used for reporting from 2003 to 2004. On page 4, line 2, the net premium income is reported net of HMO risk premiums for 2003 and 2004. However, on page 4, line 1, for 2003, the member months line included HMO member counts, but for 2004 the HMO member counts were excluded. Therefore, the drop in enrollment is due to the methodology used to report these amounts between 2003 and 2004.

EVSP markets its products through a Broker Agreement where a broker designated by a group as its Agent of Record is termed an agent and paid a commission. The commission is paid on contributions paid in cash for vision benefits according to the rate schedule contained within the Broker Agreement.

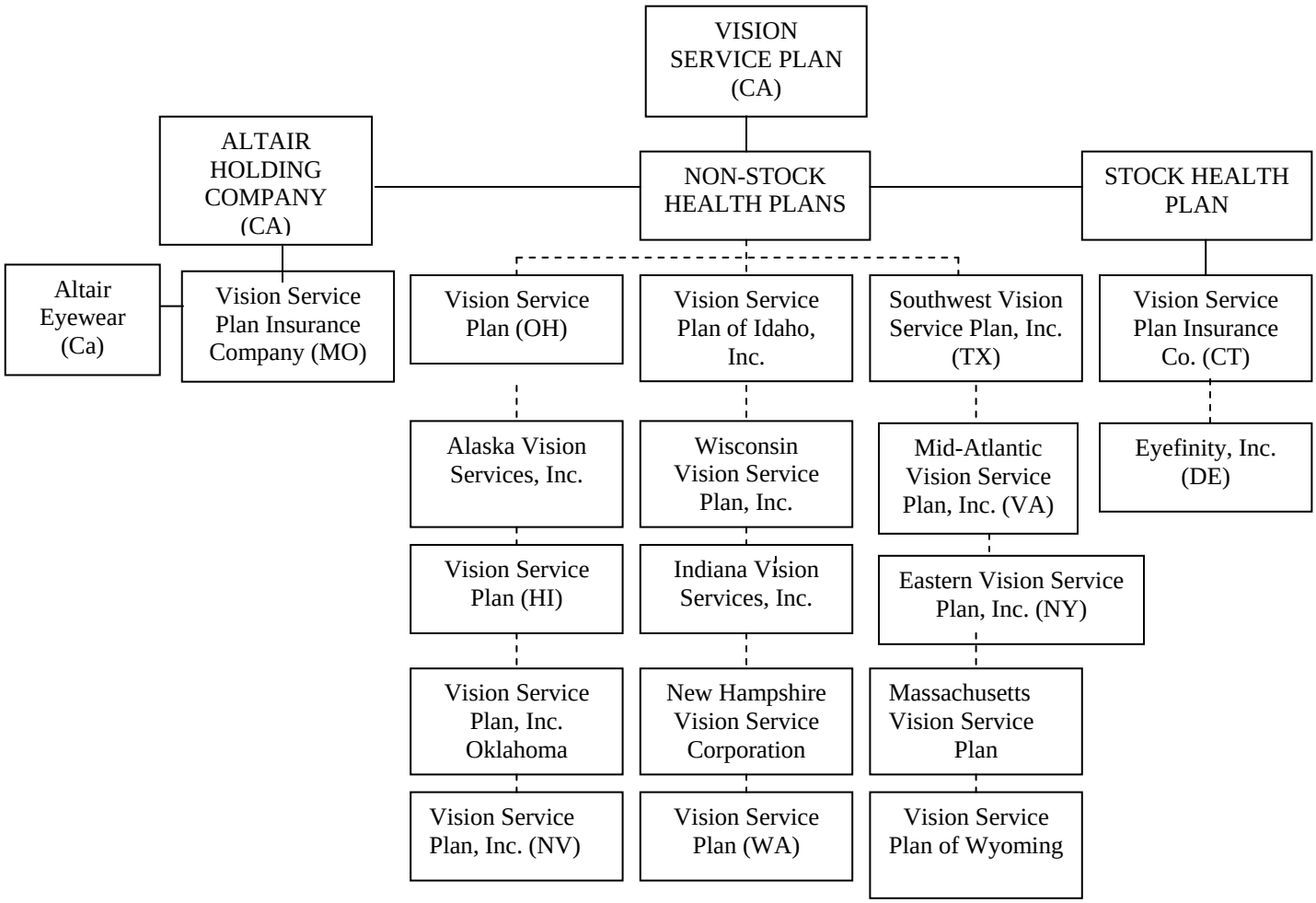
C. Reinsurance

The Plan did not maintain a reinsurance program during the period of the examination.

D. Holding Company System

The Plan is a membership corporation whose sole member is Vision Service Plan. As such, the Plan is a controlled insurer as defined in New York Insurance Law §1501(a)(4).

The following is a list of all entities affiliated with Vision Service Plan:



VSP, Inc. is a holding company and ultimate parent of Altair Holding Company, Vision Service Plan Insurance Company of Connecticut, and a 15 member vision service plan network. Altair Holding Company was organized to hold the stock of Vision Service Plan Insurance Company of Missouri. Vision Service Plan Insurance Company owns the subsidiary Altair Eyewear, a California company, organized to provide lab services. Vision Service Plan Insurance Company of Connecticut owns the stock of the subsidiary Eyefinity, Inc. a Delaware Company, organized to provide lab services. In addition, Vision Service Plan of California has a laboratory as a line of business that provides laboratory services to affiliates. Also, Vision Service Plan of Ohio has a laboratory as a line of business that provides laboratory services to affiliates. Recently, EVSP formed a subsidiary EVSP, Inc. to provide services to HMO's that it contracted with under its risk revenue program.

At December 31, 2004, the Plan was a party to an Administrative and Marketing Agreement with its parent. Pursuant to the terms of this agreement, which was effective March 7, 2001, VSP agrees to provide its administrative and marketing services to the Plan. In return for these services, the Plan pays to its parent a per claim charge equal to the total general and administrative expenses of VSP and its subsidiaries (excluding expenses charged directly to the Plan such as commissions, taxes, and audit and legal fees), divided by the total number of claims paid for EVSP.

The agreement allows insured's of the Plan to receive eye care services from participating providers of out-of-state affiliates of the Plan. Under the terms of the agreement, the Plan reimburses the affiliate for patient charges incurred on behalf of an insured of the Plan.

E. 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		$69,735,665	82.4%
Claims adjustment expenses		2,427,637	2.9%
General administrative expenses		2,490,859	2.9%
Premium deficiency reserve		1,120,520	1.3%
Net underwriting gain (loss)		8,813,912	10.4%
Premium earned	$	$84,588,593	100.0%

The Plan exceeded the benchmark for the one-year reserve development of claims to prior year capital and surplus.

One Year Development of Claims Unpaid:	
Claims Unpaid Prior Year	1,236,859
One Year Development (Claims Incurred in Prior Year)	921,317
Savings	315,542
Development of unpaid claim ratio	25.51%

F. Investment Activities

The Plan is a party to several custodian agreements for the safeguarding of its securities with the following entities: Bank of America, Banc of America Investment Services, Inc. and Merrill Lynch, Pierce, Fenner & Smith Inc. (“MLPF&S”). The Company has enacted bank agreements that include all covenants required by the Department.

G. Abandoned Property

The Plan did not comply with New York Abandoned Property Law §1316 in that it did not publish a notice of such unclaimed property as required by that law. As such, it is recommended with regard to publishing of notices of unclaimed property that the Plan comply with New York Abandoned Property Law §1316.

H. Accounts and Records

1. Risk Revenue

The examination risk revenue of $3,396,993 is $2,433,004 more than the $963,989 reported by the Plan in its 2004 filed annual statement. The amount of $963,989 reported by the Plan resulted from netting HMO premium of $3,396,993 against HMO risk claims of $2,433,044. The 2004 NAIC Annual Statement Instructions makes no provision for netting these two accounts against each other. Rather, two separate line items, Line 5 – Risk Revenue and Line 29 – Aggregate write-in for other income or expense, are provided where these amounts are to be reported gross. Because of the Plan's operations and accounting entries relative to such risk revenue as described in the next paragraph below, the gross amount of $3,396,993, was recorded as a gross amount, per this examination, at line 5 – "Risk revenue" and $2,433,044 was reclassified to line 10 – Other professional services relative to the Statement of Revenue and Expenses of the Plan's filed 2004 annual statement.

It was noted that the Plan had issued subscriber contracts to administer the vision benefits provided to its HMO clients that constituted its reported risk revenue business. The Plan defined an HMO to be a group for purpose of insurance under subscriber contracts in violation of New York Insurance Law Section 4235(c).

Although, the Plan did form an IPA, Eastern Vision Service IPA, Inc. (EVSIPA), no business has been transacted through the IPA. Therefore, the Plan violated New York State Department of Health Regulation Part 98 and retained the capitation for its own account.

It is recommended the Plan comply with Section 4235(c) of the New York Insurance Law and refrain from issuing subscriber contracts to HMOs relative to the administration of vision coverage provided to members of such HMOs.

New York Department of Health Regulation Part 98-1.18(d) (10 NYCRR 98-1.18(d)) states the following:

> "An MCO contracting with an IPA shall require that the financial records of the IPA shall account in detail for all funds received from the MCO, including where applicable, fees for services performed by the IPA, and for disbursements of all such funds."

It is recommended that the Plan comply with New York Department of Health Regulation Part 98-1.18(d) (10 NYCRR 98-1.18(d)) by transacting business through its subsidiary IPA. Such business should include the detailed accounting transactions for all funds received from the HMOs, including fees for services performed by the IPA, and for disbursements of all such funds.

It is recommended that EVSP comply with New York Department of Health Regulation Part 98-1.18(d) (10 NYCRR 98-1.18(d)) by recording management administrative fees within its accounts and records.

2. Administrative Service Contract Revenue

The Plan also provides administrative services relative to self-insured accident and health plans under an Administrative Service Contract (ASC) plan. Under the ASC plan, VSP pays claims from its own bank accounts, and subsequently receives reimbursement from EVSP under the Administrative and Marketing Agreement with its parent. The disclosure requirements for an ASC plan are found within Statement of Statutory Accounting Principle (SSAP) No. 47, paragraph 12, item b as follows:

"The statutory financial statements shall provide the following:

> ...b. Information with regard to the profitability to the administrator of all ASC plans…for which the reporting entity serves as an ASC administrator;

> For the total and each category separately provided: (i) gross reimbursement for medical cost incurred, (ii) gross administrative fees accrued, (iii) other income or expense (including interest paid to or received from plans), (iv) gross expenses incurred (claims and administrative), and (v) total net gain or loss from operations."

However, the Plan appears to have disclosed the transactions within the 2004 Annual Statement, page 25.2, Notes to Financial Statements, item 18 in accordance with the disclosure requirements for an Administrative Service Only (ASO) plan, except for the claim volume disclosure requirement. The disclosure requirements for an ASO plan differ from those of an ASC plan.

It is recommended the Plan follow the disclosure requirements for an ASC plan in accordance with SSAP No. 47, paragraph 12, item b.

It was noted that the disclosures within the Plan's filed December 31, 2004 Supplement to Annual Statement, page NY2, item 8 do not reconcile to the disclosures made within the 2004 Annual Statement, page 25.2, Notes to Financial Statements, item 18. The difference of $5,056,870 is attributable to the uncovered benefits and is the difference between the net reimbursement for administrative expenses, over actual expenses of $12,792,368 and the administrative fees earned of $7,735,498. Please see section three (3) within this report entitled, "Fee-For-Service" for a discussion of the treatment of uncovered benefits.

3. Fee-For-Service

The NAIC 2004 Annual Statement Instructions relative to Health, Statement of Revenue and Expenses, regarding Fee-for-Service reporting states the following:

> "Revenue recognized by the reporting entity for provision of health services…to members…excluded from their prepaid benefit package. Include in the inside amount the medical expenses associated with fee-for-service business."

It is recommended the Plan report revenue and medical expenses associated with uncovered benefits in accordance with the instructions for Fee-for-Service found within the NAIC 2004 Annual Statement Instructions – Health, Statement of Revenue and Expenses at page 55, line 4.

4. Parent, subsidiary and affiliates

Payments to parent, subsidiary and affiliate included reimbursements relative to the use of affiliated lab services relative to Plan members. The Plan used affiliated labs, as well as outside labs, to provide services to its members. A composite rate was used to reimburse the affiliated labs for services performed. The actual cost of services was used to reimburse outside labs. The composite rate includes a profit margin which the Plan paid to the affiliated labs.

Section 1505(a)(1) of the New York Insurance Law states as follows:

> (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;

Furthermore, routine services performed on behalf of the Plan are subject to prior notification under New York Insurance Law Section 1505(d)(3) of the New York Insurance Law.

Section 1505(d)(3) of the New York Insurance Law states as follows:

> (d) The following transactions between a domestic controlled insurer and any person in its holding company system may not be entered into unless the insurer has notified the superintendent in writing of its intention to enter into any such transaction at least thirty days prior thereto, or such shorter period as he may permit, and he has not disapproved it within such period:
> (3) rendering of services on a regular systematic basis; or

It is recommended that the Plan comply with Sections 1505(a)(1) and 1505(d)(3) of the New York Insurance Law relative to the reimbursement of services by affiliated labs.

4. FINANCIAL STATEMENTS

A. Balance Sheet

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

	EXAMINATION			PLAN	
Assets	Ledger Assets	Not Admitted Assets	Admitted Assets	Admitted Assets	Surplus Increase (Decrease)
Bonds	$1,009,450	$	$ 1,009,450	$1,009,450	$
Common Stocks	1,488,438		1,488,438	1,488,438	
Cash	591,289		591,289	591,289	
Short term investments	5,899,653		5,899,653	5,899,653	
Uncollected premiums	762,504	92,343	670,161	670,161	
Amounts receivable related to uninsured plans	7,386,174	384	7,385,790	7,385,790	
Interest and other investment Income due and accrued	57,378		57,378	57,378	
Net deferred tax asset	783,494		783,494	783,494	
Total Assets	$17,978,380	$ 92,727	$17,885,653	$17,885,653	
Liabilities					
Claims unpaid			$ 1,183,557	$ 1,183,557	$
Unpaid claims adjustment expenses			60,078	60,078	
Aggregate health policy reserves			1,120,520	1,120,520	
Premium received in advance			10,572	10,572	
Current federal income taxes			334,832	334,832	
Other expenses due and accrued			146,049	146,049	
Payable to parent			1,284,713	1,284,713	
Liability for amounts held under uninsured accident & health plans			660,298	660,298	
Total Liabilities			$4,800,619	$4,800,619	
Reserves and other funds					
Statutory reserve			$1,177,743	$ 1,177,743	
Unassigned funds			11,907,291	11,907,291	
Total reserves and unassigned funds			$13,085,034	$13,085,034	
Total liabilities, reserves, and Unassigned funds and net worth			$17,885,653	$17,885,653	

B. Underwriting and Investment Exhibit

Reserves and unassigned funds increased $8,533,964 during the five-year examination period, January 1, 2000 through December 31, 2004, detailed as follows:

Statement of Income

Underwriting income		
Premiums	$ 77,720,809	
Risk revenue	6,867,784	
Total revenue		$ 84,588,593
Deductions:		
Claims incurred	$ 69,735,665	
Claim adjustment expenses incurred	2,427,637	
Administrative expenses incurred	2,490,859	
Premium deficiency reserve	1,120,520	
Total underwriting deductions		$ 75,774,681
Net gain from underwriting		$ 8,813,912
Investment Income		
Net investment income earned	$ 980,912	
Net realized capital gains	17,818	
Net investment gain		998,730
Other income		
Other income		3,605,378
Net income before federal income taxes		$ 13,418,020
Federal income taxes incurred		5,115,019
Net income		$ 8,303,001

Capital and Surplus Account

	Gains	Losses	
Reserves and unassigned funds per report on examination as of December 31, 1999			$ 4,551,070
Net income	$ 8,303,001		
Net unrealized capital gains/(losses)		$(25,048)	
Change in non-admitted assets		(59,275)	
Change in net deferred tax asset	592,478		
Cumulative effect of change in accounting principles	191,017		
Changes in reserves and unassigned Funds		(833,590)	
Reversal of prior examination changes	365,381		
	$9,451,877	$(917,913)	
Net increase in reserves and Unassigned funds			8,533,964
Reserves and unassigned funds per Examination as of December 31, 2004			$ 13,085,034

Summary of Reserves and Unassigned Funds

	December 31, 1999	December 31, 2004	Change
Statutory reserve	$ 383,578	$ 1,177,743	$ 794,165
Contingency special surplus	1,230,000		(1,230,000)
Unassigned funds (surplus)	2,937,492	11,907,291	8,969,799
Totals	$ 4,551,070	$13,085,034	$ 8,533,964

5. CLAIMS UNPAID AND UNPAID CLAIMS ADJUSTMENT EXPENSES

The examination liability of $1,243,635 is the same as the amount reported by the Plan as of June 30, 2004.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements.

6. TREATMENT OF POLICYHOLDERS AND CLAIMANTS

In the course of this examination, a review was made of the manner in which the Plan 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 general review was directed at practices of the Plan in the following major areas:

A. Claims processing
B. Rating

A. Claims Processing

1. Prompt Settlement of Claims

The following categories of claims for the period January 1, 2004 through December 31, 2004 were reviewed: claims that took longer than 30 days to deny from the date that the Company had all the necessary information to adjudicate the claim; claims that took longer than 30 days to request further information, from the date that

the claim was reported and claims that took longer than 45 days to pay - from the date the claim and all information necessary to process the claim was received.

§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…is not reasonably clear, …such insurer…shall pay the claim…within 45 days of receipt of a claim or bill for services rendered."

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

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment…"

§3224-a(c) of the New York Insurance Law, states:

> "(c) Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes…or twelve percent per annum, to be computed from the date the claim or health care payment was required to be paid. When the

amount of interest is less (than) two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

The findings resulting from this review was that the Company failed to pay interest that was due under §3224-a(c) in four instances. Further, it was found that 28 of the 167 claims reviewed were found to be in violation of §3224-a(b) of the New York Insurance Law, as detailed below:

- 15 claims were found to be in violation of §3224-a(b), according to the Company system, with no explanation for the delay in denying the claim.
- 13 claims that contained no explanations for the delay in payment, and therefore were in violation of §3224-a(a);

An error projection formula utilized determined with 95% assurance that there existed between 38 and 76 violations of the above-mentioned sections of the New York Insurance Law.

It is recommended the Plan comply with the provisions of Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law.

2. Attribute Sample

A claims review was performed using a statistical sampling methodology covering the claims processed in 2004, to evaluate the overall accuracy and compliance environment of the Company's claims processing.

The statistical random sampling process was performed using ACL for Windows©, an auditing software program devised to test various attributes deemed to be necessary for the successful processing of claims. The objective of the sampling process was to test and reach conclusions about all predetermined attributes, individually or in combination. The review incorporated processing attributes used by Vision Service Plan in their own quality analysis of claims processing. The sample size was comprised of 167 randomly selected claims.

The sample of 167 claims was comprised of 34 denied claims and 133 paid claims. The term "claim" for the purpose of this memo is defined by the Company as the total number of items submitted by a single provider within a single claim form that is reviewed and entered into the claims processing system. A claim may consist of various lines or procedures. The basis of the Department's statistical sample of claims is the summarization of all the lines of a claim into one line (roll-up).

A paid claim was defined as any claim for which the Company was obligated to pay the claim or make the medical payment; a denied claim was one for which the Company was not obligated to pay the claim or make the medical payment. Any claim which contains at least one service line for which the Company is not obligated to pay for the service will be considered a denied claim, even if other service lines are paid (partially denied). There were thirteen claims in the sample that were partially denied.

It was found that only three (3) errors existed in the sample. This represents an accuracy rate of 98.2%.

B. Rating

The Plan was not able to document that its experience rating formula had been approved as required by New York Insurance Law §4308(b). New York Insurance Law, Section 4308(b) states in part as follows:

> "No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof…"

It is recommended that the Plan submit its experience rating formula to the Department for approval.

7. COMPLIANCE WITH PRIOR REPORT ON EXAMINATION

The prior report on examination contained the following comments detailed as follows (page numbers refer to the prior report):

ITEM		PAGE NO.
A.	Management	
1.	It is recommended that the Plan comply with New York Insurance Law §4301(k)(4) on an ongoing basis. The Plan has complied with this recommendation.	4
2.	It is recommended that the Plan obey its own by-laws in the maintenance of its board and the operation of its meetings. The Plan has complied with this recommendation.	5
3.	It is recommended that the Plan notify the Department of board changes as specified in New York Insurance Law §4301(k)(2)(B). The Plan has complied with this recommendation.	5
4.	It is recommended that the board approve all investments as required under New York Insurance Law §1411(a). The Plan has complied with this recommendation.	5
B.	Holding Company System	
	It is again recommended that the current Administrative and Marketing Agreement be amended to include a billing and settlement provision. The Plan has complied with this recommendation.	8

C. Accounts and Records

1. It is again recommended that the Plan amend its custodial agreement with the Bank of California to include a provision that the bank will give the securities held by it the same care given its own property of a similar nature. 9

   The Plan has complied with this recommendation.

2. It is recommended that the Plan amend its custodial agreement with the Bank of California to include a provision that the insurer may obtain the most recent review of the custodian's system of internal controls pertaining to the custodian's record-keeping. 9

   The Plan has complied with this recommendation.

D. Abandoned Property

It is recommended that the Plan comply with Abandoned Property Law §1316. 9

The Plan has not complied with this recommendation and it is repeated again in this Report on Examination.

E. Stocks

It is recommended that the Plan maintain its investments in compliance with the limitations noted in New York Insurance Law §1404. 13

The Plan has complied with this recommendation.

F. Uncollected Premiums

It is recommended that the Plan comply with the "Rules for the Determination of Overdue Premiums, Other Than Life Insurance Premiums." 14

The Plan has complied with this recommendation.

G. Sales and Advertising

It is recommended that the Plan maintain an advertising file in compliance with New York Regulation 34. 15

The Plan has complied with this recommendation.

H. Underwriting

1. It is recommended that the Plan comply with New York Insurance Law §4302 and limit its coverage to members in residence within the Plan's licensed area. 15

The Plan has complied with this recommendation.

I. Rating

It is recommended that the Plan obtain approval from the Department for its experience rating formula. 15

The Plan has not complied with this recommendation and it is repeated again in this Report on Examination.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Description of Plan	
	It is recommended that the Board of Directors meet quarterly at a minimum to review the quarterly financial condition of the Plan and evince fiduciary oversight.	6
B.	Abandoned Property	
	It is recommended with regard to publishing of notices of unclaimed property that the Plan comply with New York Abandoned Property Law §1316.	10
C.	Risk Revenue	
1.	It is recommended the Plan comply with Section 4235(c) of the New York Insurance Law and refrain from issuing subscriber contracts to HMOs relative to the administration of vision coverage provided to members of such HMOs.	11
2.	It is recommended that the Plan comply with New York Department of Health Regulation Part 98-1.18(d) (10 NYCRR 98-1.18(d)) by transacting business through its subsidiary IPA. Such business should include the detailed accounting transactions for all funds received from the HMOs, including fees for services performed by the IPA, and for disbursements of all such funds.	12
3.	It is recommended that EVSP comply with New York Department of Health Regulation Part 98-1.18(d) (10 NYCRR 98-1.18(d)) by recording management administrative fees within its accounts and records.	12

D. Administrative Service Contract Revenue

It is recommended the Plan follow the disclosure requirements for an ASC plan in accordance with SSAP No. 47, paragraph 12, item b. 13

E. Fee-for-Service

It is recommended the Plan report revenue and medical expenses associated with uncovered benefits in accordance with the instructions for Fee-for-Service found within the NAIC 2004 Annual Statement Instructions – Health, Statement of Revenue and Expenses at page 55, line 4. 14

F. Parent, Subsidiary and Affiliates

1. It is recommended that the Plan comply with Sections 1505(a)(1) and 1505(d)(3) of the New York Insurance Law relative to the reimbursement of services by affiliated labs. 15

G. Prompt Settlement of Claims

It is recommended the Plan comply with the provisions of Sections 3224-a(a) and 3224-a(b) of the New York Insurance Law. 21

H. Rating

It is recommended that the Plan submit its experience rating formula to the Department for approval. 22

Appointment No. ***22433***

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, ***Howard Mills***, Acting Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Barbara Finnerty

as a proper person to examine into the affairs of the

Eastern Vision Service Plan, Inc.

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

Plan

with such information as she 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 20th day of March 2006

Howard Mills
Acting Superintendent of Insurance