

OFFICE OF THE
NEW MEXICO PUBLIC REGULATION
COMMISSION
INSURANCE DIVISION



CERTIFICATE

NEW MEXICO
PUBLIC REGULATION
COMMISSION
FILED
2006 OCT 6 AM 10 10

I, Thomas R. Ruston, Superintendent of Insurance of the State of New Mexico, do hereby certify that the attached Report of Examination for the period ending May 31, 2003 on:

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

Was recently completed by *Nestor J. Romero*, Examiner-In-Charge with the Insurance Division.

Due consideration has been given to the comments of the Examiner regarding the financial condition and business affairs as reflected in this report.

The report as of this date is hereby adopted, filed and made an official record of the Division.



In Witness Whereof, I have hereunto set
my official seal On this 2nd
day of October, 2006 A.D.

Thomas R. Ruston
Acting Superintendent of Insurance

AFFIDAVIT

2006 OCT 6 AM 10 10

STATE OF NEW MEXICO

COUNTY OF BERNALILLO

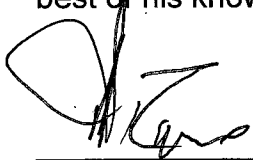
Nestor J. Romero, CPA, CFE, CIE being duly sworn, upon his oath deposes and says:

That he is an examiner appointed by the Superintendent of Insurance of the State of New Mexico;

That an examination was made of the affairs of Metropolitan Life Insurance Company, New York, New York, for the period of January 1, 2000 through May 31, 2003;

That the following twenty-eight (28) pages constitute the report thereon to the State of New Mexico Division of Insurance Superintendent;

And that the statements and data therein contained are true and correct to the best of his knowledge and belief.



Nestor J. Romero, CPA, CFE, CIE
Examiner-In-Charge

Subscribed and sworn to before me this the 27 day of September, 2006.

Isabel F. Solano
(Signature)

Isabel F. Solano Notary Public
(Print Name)

in and for the State of New Mexico

My commission expires June 06, 2009

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REPORT OF EXAMINATION

OF THE

MARKET CONDUCT AFFAIRS

OF

METROPOLITAN LIFE INSURANCE COMPANY

NAIC # 65978

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August 28, 2006

Honorable Thomas R. Rushton
Acting Superintendent of Insurance
State of New Mexico Division of Insurance
P.O. Drawer 1269
Santa Fe, New Mexico 87504-1269

Superintendent Rushton:

Pursuant to your instructions and in accordance with NMSA 1978, §§59A-4-4, an examination has been made of the business and market conduct affairs of:

METROPOLITAN LIFE INSURANCE COMPANY

with its home and administrative office at One Madison Avenue, New York, NY 10010-3690 as of May 31, 2003.

FOREWORD

This Market Conduct Examination of Metropolitan Life Insurance Company (referred to herein as the "Company") is, in general, a report by exception. This means that any findings concerning the Company's practices, procedures or files that were the subject of review may be omitted if the examiners found no improprieties.

The examination was conducted in accordance with NMSA 1978, §59A-4-4. Company personnel provided the Examiners with the information that was reviewed in order to complete this examination report.

SCOPE OF EXAMINATION

The purpose of the examination was to determine the Company's compliance with New Mexico' statutes and regulations and to determine whether the Company's operations and practices are consistent with the public interest. This examination covered the period from January 1, 2000 through May 31, 2003.

In accordance with the procedures of the New Mexico Division of Insurance, the Examiners completed preliminary finding forms ("preliminary findings" or "PF") on those files, forms and/or practices in apparent violation of New Mexico law. The preliminary findings were submitted to the Company representatives designated by Company management as being knowledgeable about the issues raised in the preliminary findings for their review and comment.

COMPANY HISTORY

The Company was founded in New York City on March 24, 1868. The Company formed Metropolitan Property and Liability Insurance Company in 1972; Metropolitan Insurance and Annuity Company in 1976; acquired State Street Research & Management Company in 1982; Texas Insurance Company in 1987; announced a merger agreement with New England Mutual Life Insurance Company in 1995; acquired GenAmerica Corporation, parent of General American Life Insurance Company and its subsidiaries, in 2000; and, converted from a mutual insurance company to a stock company in 2000. Together, with its subsidiaries the Company offers a portfolio of individual and group life insurance, annuities, pensions, group medical and non-medical insurance programs, individual and group disability, individual and group long-term care and property and casualty insurance.

The Company is rated as follows:

Moody Investors Service: Aa2 (Excellent)

Standard & Poor's: AA(Very Strong)

A. M. Best: A+ (Superior)

Fitch Ratings: AA (Very Strong)

REPORTS TO THE DIVISION

Anti-Fraud Plan—Annual Filing

The Company is required to file by July 1 of each year its anti-fraud plan. The Company admitted that it had not filed its plan for each of the years, 2000,

2001 and 2002, which is an apparent violation of NMSA 1978, §59A-16C-10(A) for each of the three years.

Long-Term Care Marketing and Suitability

The examiners requested copies of the long-term care marketing and suitability annual report filings with the superintendent for the years 2000, 2001, 2002 and 2003. The Company failed to provide evidence that the annual long-term care reports to the superintendent were filed for each of the years 2000, 2001, 2002 and 2003. As such, the company appears to be in violation of 13 NMAC 10.15.37(F).

COMPANY OPERATIONS

Confidential Abuse Information Practices Program

The Company provided both a long form and a short form of the "notice of confidential abuse information practices."

The Company stated that they first implemented their notice of confidential abuse information practices program in August 2000. They also established a confidential abuse location information program in August 2000. The Company failed to provide the examiners with a requested copy of the location information program for New Mexico applicants and policyholders subsequent to the effective date of 1/1/99, which is an apparent violation of 13 NMAC 7.5.17(A).

The Company acknowledges its failure to provide these notices consistently across all product lines. However, the Company believes that its overall and extensive consumer privacy and information security procedures

ensured the confidentiality of protected domestic abuse information. The Company also indicates that it has taken corrective action by mailing the proper notices to those individuals who should have previously received them and is effectuating system changes to ensure that appropriate notices are provided prospectively in all instances where such notices are required by New Mexico law.

TPA Agreements

Consumer Advisory Board

A managed health care plan is defined in 59A-57-3.J. as, "a health care insurer or a provider service network when offering a benefit that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health care insurer or provider service network.

"Managed health care plan" or "plan" does not include a health care insurer or provider service network offering a traditional fee-for-service indemnity benefit or a benefit that covers only short-term travel, accident-only, limited benefit, student health plan or specified disease policies."

The Company established a managed care plan and failed to establish a consumer advisory board, which is an apparent violation of NMSA 1978, §59A-57-5(B).

COMPANY COOPERATION—DATA REQUEST RESPONSE

The examiners submitted 305 data requests, throughout the course of the examination, to the Company in order to obtain the information necessary to accomplish the examination as set forth under New Mexico law and in accordance with the instruction provided by the New Mexico Division of Insurance. The examiners took the following steps in an effort to expedite the examination process:

- Provided the Company on a regular basis, generally weekly, an updated log of outstanding data requests
- Met with the examination coordinator on a regular basis, generally weekly, to discuss outstanding data requests;
- Requested periodic meetings with a Company vice-president to express the examiners' concerns about the Company's delays in providing required information;
- Responded promptly to questions raised by the Company regarding data request issues;
- Advised the Company that we would be willing to discuss, and modify if necessary, any data requests that would be difficult for the Company to provide; and,
- Extended response due dates for data requests from 5 calendar days to 7 calendar days.

The Company represented to the examiners that it would cooperate with the examiners and would provide the requested information as rapidly as possible. However, the Company did not timely respond to many data requests, which significantly contributed to the examination cost. As such, it appears that the company is in violation of NMSA 1978, §59A-4-7(B).

MARKETING AND SALES

Fixed Annuity Buyer's Guide

The Company stated that the Buyer's Guide is distributed either by the sales agent at the time of application, or as part of the Company's welcome package for new applicants. Twenty-one non-variable annuity contracts were issued during the period of the examination. The Company indicated that the Buyer's Guide distribution was inadvertently discontinued during a transition from hard copy to electronically generated guides.

Nine (42.9%) of 21 non-variable annuity contracts, that were issued between April, 2002 and May 31, 2003, were criticized because the Company failed to provide an Annuity Buyer's Guide at or before the time of application, which is an apparent violation of 13 NMAC 9.12.8(A).

LTC AARP and Employer Group Solicitation Kits

AARP

The Company provided the examiners with specimen solicitation kits provided to persons who expressed an interest in obtaining coverage through the

program offered to AARP members. The administrative code requires that when coverage is offered through an association, the solicitation material must include a brief description of the methodology used by the association to select the insurer and the plans being offered. The AARP solicitation kits did not contain a description of how the association selected the Company as the insurer. Failure to provide the description is an apparent violation of 13 NMAC 10.15.36.C (2).

FORMS

Report filings with the superintendent

The Company failed to submit their variable universal life insurance prospectuses to the superintendent for approval prior to their use in New Mexico, which is an apparent violation of 13 NMAC 9.8.13.A (2).

The Company failed to submit their variable universal life insurance illustrations to the superintendent for approval prior to their use in New Mexico, which is an apparent violation of 13 NMAC 9.8.13.A. (2).

The Company failed to submit their variable universal life insurance anniversary reports to policyholders to the superintendent for approval prior to their use in New Mexico, which is an apparent violation of 13 NMAC 9.8.13.A(3).

INDIVIDUAL ANNUITIES

Applications Issued

The company provided a listing of 2,505 individual annuities issued during the examination period. The examiners selected a sample of 55 files from the

population for review. All 55 files appeared to fit the sample criteria. The review was considered complete after 50 files were reviewed.

Four of the fifty files reviewed failed to contain, as part of each completed application, a statement signed by the writing agent as to whether he or she knew that replacement was involved which is an apparent violation of 13 NMAC 9.6.10(A).

DISABILITY INCOME

Individual Disability Income—Issued Applications

Met Life provided a listing of 52 individual disability income files, which represented the population issued during the time period of the examination. Four of the files contained documentation indicating that the applicant/insured was not a resident of New Mexico at the time the policy was issued. These files were eliminated which left 48 files remaining to review.

In eight instances, the Company accepted business from an agent who was not licensed in the state of New Mexico at the time the application was written which is an apparent violation of NMSA 1978, §59A-12-6(B).

In sixteen instances, the Company accepted business from an agent who was not appointed in the state of New Mexico at the time the application was written which is an apparent violation of NMSA 1978, §59A-11-12(A).

In eight instances the Company paid commissions to an agent who was not licensed in the state of New Mexico at the time the application was written which is an apparent violation of NMSA 1978, §59A-12-24(B).

In nine instances, the Company accepted new business on a New Mexico resident submitted on an application form which was not filed with nor approved by the superintendent for use in New Mexico which is an apparent violation of NMSA 1978, §59A-18-12(A).

Short Term Disability Claims

Denied

The company provided a listing of 79 group STD claims denied during the examination period. The examiners selected 55 of the 79 files for review. Seven of the 55 files did not meet the sample criteria and the sample was comprised of 48 files, which were reviewed at the company's offices in Utica New York.

On claim file NM STD D-15 the Company offset the benefit amount by the amount of Social Security benefits being received by the claimant as a result of the death of her spouse. This award should not offset the amount of disability income benefit due the insured under her own right. The examiners recommend that file NM STD D-15 be reopened by the company and appropriate benefits paid.

Four of the forty-eight files reviewed were non-compliant because the company failed to promptly provide the insureds with a reasonable explanation of the basis relied on in the policy in relation to the facts or applicable law for a denial of the claim.

INDIVIDUAL LIFE INSURANCE

Internal and External Replacements

The company provided a copy of their Replacement Register as well as replacement listings, which indicated that 131 life insurance contracts were replaced during the examination period.

In thirteen instances, the file reviewed failed to include documentation that the Company had sent written communication to the existing insurer advising of proposed replacement within three working days of the date that the application was received which is an apparent violation of 13 NMAC 9.6.10.B (2).

In five instances, the file reviewed failed to include a policy summary with the communication sent to the existing insurer advising of the proposed replacement which is an apparent violation of 13.9.6.10.B (2) NMAC.

In three instances, the file reviewed failed to include premium or contract contribution amounts and to identify the appropriate prospectus in communications sent to existing insurers advising of proposed replacements which is an apparent violation of 13 NMAC 9.6.10.B (2).

In nine instances, the file reviewed was non-compliant because the replacement notice provided to the applicant was not in the form required by the rule, which is an apparent violation of 13 NMAC 9.6.14.

LONG-TERM CARE INSURANCE

Individual Long-Term Care

Applications Issued

The Company provided a listing of 104 Issued LTC applications. A random sample of 55 files was requested for review, of which 54 files were provided.

In a few instances, the files reviewed were non-compliant because there was no evidence that an Outline of Coverage form was provided to the applicant at the time the person completed the application form which are apparent violations of NMSA1978 §59A-23A-6(I) and 13 NMAC 10.15.42.

In a few instances, the files reviewed that were issued after February 25, 2002 were non-compliant because there was no evidence that a Notice of Privacy Policies and Practices was provided to the applicant at the time the person completed the application form which is an apparent violation of 13 NMAC 1.3.8(A).

In a few instances the files reviewed were non-compliant because there was no evidence that the applicant accepted or signed the appropriate statement to reject the inflation coverage option at the time the person completed the application form which are apparent violations of 13 NMAC 10.15.22(G)(1) & (2).

In a few instance the files reviewed were non-compliant because there was no evidence that a Shopper's Guide was provided to the applicant at the

time the person completed the application form, which is an apparent violation of 13 NMAC 10.15.44.

Group Long-Term Care

Certificates Issued

The Company provided a listing of 369 individual long-term care applications for which policies were issued. A random sample of 55 files was requested for review. The Company provided 50 files, which were reviewed by the examiners.

In fifteen instances, the Company used an application for coverage under a group long term care policy that had not been filed with and approved by the superintendent which are apparent violations of NMSA 1978, §§59A-18-12(A), 59A-23A-6(H), and 13 NMAC 10.15.34.

In thirty two instances, the application did not contain an option to offer inflation protection in the manner set forth in the administrative code which is an apparent violation of 13 NMAC 10.15.22(G)(1) & (2).

Certificates Declined

The Company provided a listing of 222 declined individual long-term care applications. A random sample of 55 files was requested for review.

Twenty-three files reviewed were non-compliant because Metropolitan Life used application forms that were not filed and approved by the superintendent

which are apparent violations of NMSA 1978, §§59A-18-12(A), 59A-23A-6(H) and 13 NMAC 10.15.34.

Sixteen files reviewed were non-compliant because there was no evidence that the applicant accepted or signed the appropriate statement to reject the inflation coverage option at the time the person completed the application form which are apparent violations of 13 NMAC 10.15.22(G)(1) & (2).

AARP and Employer Group Replacements

The Company provided copies of Long Term Care Lapse and Replacement Reports that had been filed with the superintendent wherein it was indicated that there was only one individual replacement for long term care. Upon review of group long-term care issued certificates it became apparent that there were certificates issued which were replacing long-term care coverage in effect with other insurers. Upon inquiry by the examiners the Company provided a listing of 24 group long-term care files wherein replacement had been indicated. The examiners requested all 24 of the files and the Company provided 23 of the 24 with no explanation of the reason that the 1 file was not submitted.

In a few instances, the Company either did not notify the carrier being replaced or did not provide notification within 5 working days of receipt of the application of the pending replacement, which is an apparent violation of 13 NMAC 10.15.23.C.

In a few instances, the Company did not send the required replacement notice to the insured, which is an apparent violation of 13 NMAC 10.15.25.

METMASS GROUP MAJOR MEDICAL INSURANCE

Small Group Life and Health

Coverage Terminated

The company provided a listing of 138 employees that were terminated from small group coverage during the examination period. The examiners selected a sample of 55 termination files for review.

Thirty files reviewed were non-compliant because the Company failed to notify each employee in writing, upon the employee's termination of employment with the group insured, of the conversion privileges under the policy, which is an apparent violation of NMSA 1978, §59A-18-16(E).

Seventeen files reviewed were non-compliant because the Company failed to provide a certificate of periods of creditable coverage, which included the waiting period imposed on the individual, to employees who ceased to be covered under the plan, which is an apparent violation of NMSA 1978, §59A-23E-7.B(2).

Small Group Claims

Small Group Major Medical—Mandated Benefits

The examiners requested duplicate certificates, which had been issued to six individuals covered under the MetMass small employer group program. The examiners found that the six certificates represented coverage under five unique employer groups as shown below, one of which, according to the Company, was a Texas based employer so the certificate provided was a Texas certificate. The Company provided certificates for the following groups:

Group Number	Certificate Number
Group 1	CERT 500-50.2-REV-1/89
Group 2	CERT 500-50.2-REV-1/89
Group 3	CERT 500-50.2-REV-1/89
Group 4	CERT 500-50.2-REV-1/89
Group 5	TR-TX-1/98

A certificate of insurance issued by an insurance company to an employee of a small group employer where such employee is a resident of New Mexico must comply with all of the requirements set forth as necessary for group policies issued to residents of New Mexico without regard to the situs of the group master policy. The examiners review of New Mexico statutes appears to support this position. Specifically, NMSA 1978, §59A-23(E)(2) sets forth definitions of the following terms:

"P. "group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as

medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

R. "health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise, and items, including items and services paid for as medical care, pursuant to any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

S. "health insurance issuer" means an insurance company, insurance service or insurance organization, including a health maintenance organization, that is licensed to engage in the business of insurance in the state and that is subject to state law that regulates insurance within the meaning of Section 514(b)(2) of the federal Employee Retirement Income Security Act of 1974, but "health insurance issuer" does not include a group health plan;"

NMSA 1978, §59A-23(C)(3)(I) defines, as it relates to small employer insurance plans, a health benefit plan as: "means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental or disability income insurance, Medicare

supplement coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance or automobile medical-payment insurance; “

The examiners noted that certificate form CERT 500 – 50.2 – Rev – 1/89 and certificate form TR-TX-1/98 did not explicitly set forth all of the provisions mandated by New Mexico statutes. The examiners believe that the following are apparent violations of the cited statutes:

Five (100%) of the five certificates reviewed limited the benefits for temporomandibular joint disorder to a lifetime maximum of \$2,000 and do not provide benefits for Craniomandibular joint disorders which is an apparent violation of NMSA 1978 § 59A-16-13(1).

Five (100%) of the five certificates reviewed require an individual to be insured for at least three months prior to being eligible for conversion upon the occurrence of certain events, where the statute does not provide for any waiting period for conversion eligibility, which is an apparent violation of NMSA 1978 § 59A-18-16.

Four of the five certificates reviewed did not affirmatively state that coverage will be provided for adopted children which is an apparent violation of NMSA 1978 § 59A-22-34(1).

Five of the five certificates reviewed did not affirmatively state that benefits are available for maternity medical transport, which is an apparent violation of NMSA 1978 § 59A-22-35.

Four of the five certificates reviewed did not affirmatively state that benefits are available for home health care, which is an apparent violation of NMSA 1978, § 59A-22-36.

Four of the five certificates reviewed did not affirmatively state that benefits are available for mammograms which is an apparent violation of NMSA 1978, § 59A-22-39.

Four of the five certificates reviewed did not affirmatively state that benefits are available for minimum hospital stays following a mastectomy or lymph node biopsy which is an apparent violation of NMSA 1978, § 59A-22-39(1).

Five of the five certificates reviewed did not affirmatively state that benefits are available for cytologic screening which is an apparent violation of NMSA 1978, § 59A-22-40.

Four of the five certificates reviewed did not affirmatively state that benefits are available for diabetic drugs, devices and self-management training which is an apparent violation of NMSA 1978, § 59A-22-41.

Three of the five certificates reviewed did not affirmatively state that benefits are available for contraceptive devices and drugs when prescription drug benefits are available which is an apparent violation of NMSA 1978, § 59A-22-42.

Five of the five certificates reviewed provided a limited benefit for alcohol treatment, which is an apparent violation of NMSA 1978, § 59A-23-6.

Five of the five certificates reviewed provided for a pre-existing condition limitation period of 6 months without treatment or 12 months if treatment is given

within 6 months prior to the effective date which is an apparent violation of NMSA 1978, § 59A-23C-7(1).

Five of the five certificates reviewed provided a limited benefit for mental health treatment, which is an apparent violation of NMSA 1978, § 59A-23E-18.

Four of the five certificates reviewed did not provide a clear and concise description of the required grievance procedures set forth in bold face type which is an apparent violation of NMSA 1978, § 59A-57-4.

Mandated Benefits Effective July 1, 2003

The Company did not provide a benefit for treatment of genetic inborn errors of metabolism for policies issued or renewed after July 1, 2003, which is an apparent violation of NMSA 1978, §59A-22-41(1).

Small Group Major Medical Claims Audit

The examiners found in reviewing the certificates issued to New Mexico resident employees of certain small employers that certain mandated benefits were not indicated as being covered benefits under the terms of the certificates. The examiners provided the Company with the following list of mandated benefits:

Statutory Citation	Brief Summary of Mandated Benefit or Required Policy Provision
§59A-16-13.1	Craniomandibular and temporomandibular joint disorders must be covered on the same basis as any other illness.
§59A-22-34.3	Immunizations must be provided in accordance with recommendations of the American Academy of Pediatrics.
§59A-22-35	Medical transport to protect the life of the infant or mother to the nearest available tertiary care facility if maternity coverage is provided.
§59A-22-36	Home health care—100 visits per year
§59A-22-39	Mammograms—1 age 35-39, biennially ages 40-49,

Statutory Citation	Brief Summary of Mandated Benefit or Required Policy Provision
	annually thereafter
§59A-22-39.1	Mastectomies and lymph node dissection—minimum stay of 48 hours following mastectomy and 24 hours following lymph node dissection.
§59A-22-40	Cytologic screening—pap smears
§59A-22-41	Diabetes coverage, including supplies and education/training.
§59A-22-42	Coverage for prescription contraceptive devices and drugs approved by the FDA when prescription drug coverage is provided.
§59A-23-6	Alcohol treatment must provide coverage for up to 30 inpatient days and 30 outpatient visits per benefit period, which benefit period cannot be greater than one year. May be limited to a lifetime maximum of two benefit periods.
§59A-23E-18	Mental health benefits must be provided on the same basis as any other illness. May be reduced if premium increase will exceed 1 ½% and is negotiated with the employer.

The examiners requested that the Company either certify that it is providing all of the mandated benefits as required by New Mexico statutes or that it perform an audit of claims denied during the time frame of the examination for conditions or treatment that are subject to the state mandates. The Company responded with a certification that it was providing benefits for the following mandates: craniomandibular and temporomandibular joint disorders and medical transport. The Company indicated that it would conduct an audit of denied claims to determine if any claims were denied inappropriately. The Company volunteered to promptly adjudicate any claims determined to have been inappropriately denied and to include in any claims payments the appropriate interest amount. The Company stated that they paid, as a result of the claims audit, an additional benefit of \$101,238.55 and interest in the amount of \$19,129.15 for a total restitution amount of \$120,367.70. The audit specifically

identified the following claims as not having been appropriately paid at time of initial submission:

In a few instances, the Company failed to provide coverage for contraceptive devices or drugs as required by New Mexico statute, which is an apparent violation of NMSA 1978, §59A-22-42.

In a few instances, the Company failed to provide coverage for childhood immunizations as required by New Mexico statute, which is an apparent violation of NMSA 1978, §59A-22-34(3).

The Company failed to provide coverage for mental nervous conditions as required by New Mexico statute, which is an apparent violation of NMSA 1978, §59A-23E-18. The Company acknowledged its initial failure to properly cover claims related to these conditions, but has subsequently readjudicated and paid with interest all of the affected claims and has effectively implemented system changes to assure that mental/nervous claims are processed and paid appropriately.

In a few instances, the Company failed to provide coverage for mammograms as required by New Mexico statute, which is an apparent violation of NMSA 1978, §59A-22-39.

Large Group Claims

Major Medical Provider Paid Claims

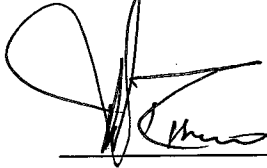
The Company provided a listing of 2,368 large group major medical claims paid to providers during the examination period. The examiners selected a random sample of 55 files for review.

A few files reviewed were non-compliant because the Company failed to pay interest at the rate of 1.5% per month on manually submitted clean claims received from providers which were not paid within 45 days after receipt, which are apparent violations of NMSA 1978, §59A-2-9.2.B(2). The Company has subsequently paid interest to these consumers.

ACKNOWLEDGEMENT

Melvin Mohs, Jerry Paugh, Jim Dargavel, and Jimmy Potts participated in this examination.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'N. Romero', is written over a horizontal line.

Nestor J. Romero, CPA, CFE, CIE
Examiner-in-Charge