Report of Examination

MODIFIED

(Market Conduct)

of

The MEGA Life and Health Insurance Company

NAIC Company Code 97055

of

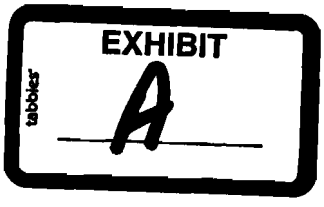
Oklahoma City, Oklahoma

as of

December 31, 2007

By Representatives of the

Oklahoma Insurance Commissioner



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SALUTATION

North Richland Hills, Texas
March 25, 2009

Honorable Kim Holland
Insurance Commissioner
State of Oklahoma
2401 NW 23rd Street, Suite 28
Oklahoma City, Oklahoma 73107

Commissioner Holland:

Pursuant to your instructions and in compliance with the provisions of Title 36 of the Oklahoma Statutes, rules, regulations and procedures of the Oklahoma Insurance Department, and the procedures established by the National Association of Insurance Commissioners, an examination of the market conduct activities has been conducted of:

The Mega Life and Health Insurance Company
of
Oklahoma City, Oklahoma

at their administrative office located at

9151 Boulevard 26
North Richland Hills, Texas 76180-5605

The report thereon, as of December 31, 2007 is herein respectfully submitted.

FOREWORD

This examination report reflects the Oklahoma insurance activities of The MEGA Life and Health Insurance Company, hereinafter referred to as the "Company". The examination is, in general, a report by test, wherein each test applied during the examination is stated and the results are reported, whether favorable or unfavorable. The Commissioner of Insurance of the State of Oklahoma is hereinafter referred to as the "Commissioner" and the Insurance Department of the State of Oklahoma is hereinafter referred to as the "Department" or the "OID."

SCOPE OF EXAMINATION

The examination of the Company was conducted pursuant, but not limited to, Title 36 §§ 309.1 - 309.7, 1203 - 1220, 1250.1 - 1250.16, 1435.2 - 1435.38, 4030.1, 4112 and 6901 - 6951 of the Oklahoma Insurance Code and Oklahoma Administrative Code § 365:40-1-1 through 365:40-5-130. In reviewing material for this report, the examiner relied primarily on records and information maintained by the Company.

The purpose of this examination was to determine compliance by the Company with Oklahoma Insurance Laws and Regulations, and to determine if the Company's operations were consistent with the public interest. The examination included, but was not limited to, the following areas of the Company's operations:

A. Company Operations/Management;
B. Complaint Handling;
C. Producer Licensing;
D. Marketing and Sales;
E. Underwriting;
F. Policyholder Service and
G. Claim Practices.

In cases where samples were selected and file sizes warrant, error ratios are projected to indicate a maximum high or low at a 95% level of confidence. Some files may contain multiple errors, which are indicated by category, but are counted only once in determining the error ratio.

The examination period was from January 1, 2005 through December 31, 2007. The examination took place in the Company's North Richland Hills administrative office.

COMPANY HISTORY

The Company was originally incorporated in Florida on November 5, 1981 and commenced writing business on June 15, 1982 as ETATS Corporation. The name changed to Orange State Life and Health Insurance Company later in 1982. United Insurance Companies, Inc., a Delaware holding company, purchased the company in 1988. The name changed to U.S. Guardian Health Insurance Company in 1989. In 1990, the Company was re-domesticated to Oklahoma and the name was changed to The MEGA Life and Health Insurance Company.

On March 29, 2006 UICI, the prior parent of MEGA, completed the merger agreement providing for the acquisition of the Company by affiliates of a group of private equity investors, including The Blackstone Group, Goldman Sachs Capital Partners and DLJ Merchant Banking Partners. On April 14, 2006, UICI announced that it has changed its corporate identity to HealthMarkets, Inc.

The Company is authorized to transact business in the District of Columbia and all states except New York.

Premium Production

Company premium production for Oklahoma compared to the total company for the examination period is shown below:

	2005		2006		2007	
	Health	Life & Annuity	Health	Life & Annuity	Health	Life & Annuity
Oklahoma	26,032,748	1,771,651	26,276,761	1,746,903	22,095,091	636,063
Total company	1,324,296,907	19,998,693	1,291,213,671	19,187,652	1,048,677,619	18,034,512

COMPANY OPERATIONS/MANAGEMENT

MGA, GA, TPA Oversight

The Company has not used any Managing General Agent, General Agent or Third Party Administrator to process Oklahoma business during the examination period other than Caremark, who provides management of the prescription benefit and EyeMed who provides service on the vision care program. A sampling of the vision care claims were reviewed as part of the examination. Life Assurance Company, Inc. administers a small portion of the credit insurance policies written by the Company. These were reviewed within the sampling of credit claims.

Internal Audits

The Company provided a list of internal audits performed on various areas of operation within the organization. Summaries of those reports indicated the findings and recommended management action required to correct deficiencies. Follow-ups were scheduled to make sure corrections were accomplished. A team of ten (10) trained claim auditors regularly select files for review under a written procedure known to examiners as well as the auditors. Detailed and summary reports are made available to claims management.

Anti-Fraud

The Company's Anti-Fraud training procedures and materials were reviewed. The Company's Special Investigations Unit (SIU) works closely with the various states to monitor and report suspected fraud. Materials include information on identifying possible fraud on the part of providers, insureds, employees and agents. Investigative methods are documented in some detail.

Certificate of Authority

A copy of the Company's current Certificate of Authority issued by the State of Oklahoma Insurance Commissioner was reviewed and found to be in conformity with the Company's operations.

Disaster Recovery

The corporate Business Continuity Program (BCP) provides a detailed overview of the various procedures developed to assure a rapid and successful return to essential business activities when interrupted by any of several reasons. The BCP provides both corporate and detailed operational level plans necessary to resume operations. Testing and trials are done at regular intervals. Updates are at least annual. The Oklahoma City location has its own detailed plan.

Computer Systems

The Corporate (North Richland Hills) and the Oklahoma City locations each have a similar role based access protocol which is reviewed and modified as required. System back-ups, an important part of the recovery plan, play an extensive part in data security as well.

Board of Directors' Meeting Minutes

The Board of Directors' meeting minutes for the examination period were reviewed without adverse findings.

Privacy

Copies of the Company's privacy practices and notices were reviewed without comment.

CONSUMER COMPLAINTS

The Company was requested to provide a listing of all the Oklahoma complaint files for the period January 1, 2005 through December 31, 2007. All 142 files on the complaint register were selected for review. Seventy-four (74) complaints were from the Department and sixty-eight (68) complaints were filed directly by the claimant. There were fifteen (15) errors, for an error ratio of 10.6%. All of the errors were in the Time Studies section of the review.

Complaint Time Studies

For these studies, inquiry response times are measured in terms of calendar days to comply with Section 1250.4 of Title 36 of the Oklahoma Statutes. Twenty (20) calendar days are allowed for a response to an inquiry from the Commissioner. Correspondence from a claimant requires a response within thirty (30) calendar days.

A review of the complaint files indicated that fifteen (15) inquiries were not responded to within the time allowed by the above statute. The files are listed below showing the Company assigned complaint numbers and the number of service days to respond. Three (3) of the errors were on inquiries from the Department and twelve (12) were on direct complaints from the claimant.

COMPLAINT NO.	COMPLAINT TYPE	DATE RECEIVED	DATE CLOSED	DAYS OPEN
CM0764510	OID	02/26/07	04/06/07	39
CM0766952	OID	04/24/07	05/25/07	31
CM0781625	OID	10/05/07	10/31/07	26
CM0766547	Attorney	04/18/07	10/19/07	184
CM0774508	Attorney	08/03/07	10/31/07	89
CM0776531	Attorney	08/14/07	09/21/07	38
CM0777996	Attorney	08/30/07	11/08/07	69
CM0763331	Consumer	01/22/07	03/28/07	65
CM0763378	Consumer	01/22/07	03/12/07	49
CM0764285	Consumer	02/20/07	03/28/07	36
CM0768324	Consumer	06/11/07	07/26/07	45
CM0769724	Consumer	06/25/07	08/10/07	46
CM0782955	Consumer	09/28/07	*	94
CM0786401	Consumer	11/19/07	*	42
CM0786532	Consumer	11/20/07	*	44

* file open as of 12/31/07

The Company has established complaint handling guidelines to bring response times into compliance.

No other discrepancies were noted in this section of the examination.

OID COMPLAINTS SUMMARY

1. Total population 74
2. 19 complaints resulted in additional payments
3. 3 cases open for more than 20 days

REASON	NUMBER
Alleged misrepresentation by agent	12
Benefit dispute	10
Billing	0
Cancellation	2
Claim denial	17
Claim handling	1
Claim delays	9
Customer service	6
Underwriting	4
Rate increase	2
Premium refund	4
Other	7

DIRECT COMPLAINTS SUMMARY

1. Total population 68
2. 19 complaints resulted in additional payments
3. 12 cases were open more than 30 days

NUMBER OF COMPLAINTS BY REASON

REASON	NUMBER
Alleged misrepresentation by agent	13
Benefit dispute	15
Cancellation	3
Claim denial	15
Claim handling	6
Fraud/Forgery	3
Underwriting	3
Rate increase	4
Premium refund	3
Other	3

No other discrepancies were noted in this section of the examination.

Complaint Handling

No discrepancies were noted in this section of the examination.

MARKETING AND SALES

The Company provided copies of files on policies, brochures, applications and producer training material on policies offered for sale in Oklahoma during the examination period. A selection of the material was reviewed including the Company web site as it related to consumer products.

Advertising

Advertising items submitted by the Company were reviewed for compliance with Oklahoma regulations regarding advertising.

Of the thirty-four (34) items submitted for review, fourteen (14) errors were noted for an error ratio of 41%. The errors are detailed below.

— Point of Sale brochures state, in a section titled "The Mega Difference," that the products offer "24 hour coverage on or off the job*" in ten (10) point type with a six (6) point type footnote that stipulates (*If not covered under a Worker's Comp or similar plan).

Oklahoma regulation 365:10-3-4, states:
"All information required to be disclosed by this Part shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading"

Oklahoma regulation 365:10-3-5(a) states:
"The format and content of an advertisement of an accident, disability or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive".

Oklahoma regulation 365:10-3-6(C) states:
"An advertisement shall not contain descriptions of a policy limitation, exception or reduction, worded in a positive manner to imply that it is a benefit.... Words and phrases used in an advertisement to describe such policy limitations, exclusions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered".

The Company disagreed that this represented a violation. In deference to the examiners' concerns, the Company agreed to change the brochures upon reprint to bring the footnote into the body of the text, as shown below:

> *Coverage on or off the job*
> *Unless covered by Worker's Compensation or similar plan.*

The examiners do not necessarily agree this change will satisfy the requirements of Oklahoma regulation 365:10-3-6(C).

— Oklahoma regulation 365:10-3-5 states:

(a) The format and content of an advertisement of an accident, disability or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the State Insurance Commissioner from the overall impression that the advertisement may be reasonably expected to creates upon the person of average education or intelligence, within the segment of the public to which it is directed.

(b) Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which are clear only by implication or by familiarity with insurance terminology, shall not be used.

Brochure M/CCP/CCP+OK 2/08, on the inside front cover, contains statements purportedly made by some unnamed Association regarding its commitment to making quality insurance coverage available to the prospective applicant. Also alleged is the Association's requirement that the insurance carrier provide:

- Quality Insurance Options
- Top-Notch Customer Service

The above statements are in violation of the above referenced regulation.

The Company agreed the statements would be difficult to support and document. The company will be revising the page and replace the sentences with:

- Flexible Insurance Options
- A Portfolio of Health and Ancillary Insurance Products

— Oklahoma regulation 365:10-3-5 states:

(a) The form and content of an advertisement of an accident, disability or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the State Insurance Commissioner from the overall impression that the advertisement may reasonably be expected to create upon the person of average education or intelligence, within the segment of the public to which it is directed.

(b) Advertisements shall be truthful and not misleading in fact or implication. Words or phrases, the meaning of which are clear only by implication or by familiarity with insurance terminology, shall not be used.

In a presentation script M/000515 the Agent is told to say "I am familiar with many different plans" and later to say "their (the NASE association) goal is to even the playing field between large companies and small businesses." The first statement assumes extensive insurance experience before becoming a MEGA agent. The second statement would imply lower premium cost and (underwriting) advantages that do not exist. Both of these statements would have the tendency to mislead or deceive.

The company agreed that the statements were unclear and the scripts were currently being reviewed and revised to remove the statements. Further, the agents' access to these scripts would be removed until after revision.

No other discrepancies were noted in this section of the examination.

PRODUCER LICENSING

Producer licensing and appointment records were reviewed for compliance with Oklahoma Statutes and Administrative Code.

From a listing of 780 producers active with the Company during the examination period, twenty-nine (29) terminated producers' files were randomly selected for review. Twenty-five (25) errors were found for an error ratio of 86.2%. All of the errors were related to Section 1435.16 of Title 36 of the Oklahoma Statutes which states:

A. An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the Insurance Commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the Insurance Commissioner, if the reason for termination is one of the reasons set forth in Section 13 of this act or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in Section 13 of this act. Upon the written request of the Insurance Commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

B. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason not set forth in Section 13 of this act, shall notify the Insurance Commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the Insurance Commissioner. Upon written request of the Insurance Commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

C. The insurer or the authorized representative of the insurer shall promptly notify the Insurance Commissioner in a format acceptable to the Insurance Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Insurance Commissioner in accordance with subsection A of this section had the insurer then known of its existence.

D. 1. Within fifteen (15) days after making the notification required by subsections A, B and C of this section, the insurer shall mail a copy of the notification to the producer at the producer's last-known address. If the producer is terminated for cause for any of the reasons listed in Section 13 of this act, the insurer shall provide a copy of the notification to the producer at the producer's last-known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

While some of the errors related to missing documents, the primary error was lack of providing the producer with a copy of the information regarding the termination of appointment as required by the above code section. The Company agreed that only minor adjustments to their procedures and letter content would bring them into compliance.

No other discrepancies were noted in this section of the examination.

POLICY OWNER'S SERVICE

Policy owners' service files were examined for timeliness and adequacy of action and response to service requests. A sampling of non-forfeiture transactions and notifications were reviewed. Sample letters and procedures were also reviewed.

From a total population of 182 surrenders and other non-forfeiture transactions done during the examination period a selection of seventy-five (75) were randomly selected for review. Three (3) errors were found for an error ratio of 4%. The errors were all involved with the wrong non-forfeiture option being employed when premium payments ceased. All of the errors were related to Section 3610 of Title 36 of the Oklahoma Statutes. They are listed below.

POLICY NO.	ACTION	COMMENTS
B0046050	RPU	ETI WAS THE CORRECT OPTION
B0046095	RPU	ETI WAS THE CORRECT OPTION
BQ2006010	ETI	AUTO PREM LOAN IS THE DEFAULT OPTION

The company agreed that Extended Term Insurance (ETI) instead of Reduced Paid Up (RPU) should have been provided on the first two and that Automatic Premium Loan should have been applied in the third instance. The Company contacted the policyholders and corrected the mistakes.

It was brought to the attention of the Company that the explanation letters that were sent out with the RPU and ETI notifications were not well written and offered none of the other policy options to the policy holder. The Company indicated the letters would be redesigned to better explain all policy options available.

The information on the voucher part of the surrender or loan check contained little information of value to the recipient and often contained information protected by the Privacy Act. The Company is in the process of working with the vendor to provide more meaningful information and eliminate any private information.

No other discrepancies were noted in this section of the examination

UNDERWRITING

Underwriting files are reviewed to determine if the Company's treatment of the public is in compliance with applicable statutes, rules and regulations. Underwriting manuals and procedures are reviewed for any indication of unfair discrimination. Forms and applications are checked to make sure they have been filed with the Department when required.

— Title 36 O.S. § 6060.3(a)
A. Any health benefit plan, including the State and Education Employees Group Health Insurance plan, that is offered, issued or renewed in this state on or after January 1, 2005, that provides medical and surgical benefits shall provide coverage for routine annual obstetrical/gynecological examinations.

Routine annual obstetrical/gynecological examinations are not covered under the base plan or amendatory endorsement for six (6) plans: 26026 ppo ssmb careone plus, 26026 ppo ssmb care one, 26026 ppo cchbp care one plus, 26026 ppo cchbp care one, 26025 ssmb care one value and 26025 cchbp care one value as required by the above code section.

The Company had filed and received approval for the corrected Amendatory Endorsements before the writing of this report.

No other discrepancies were noted in this section of the examination.

CLAIM PRACTICES

The claims practices were examined for efficiency of handling, accuracy of payment, compliance to Oklahoma Statutes and Regulations, and adherence to contract provisions.

A claim is taken to be a demand for payment by an insured or third party claimant under coverage against the insurer, which claim is:

Paid by the insurer as:

1. Full recompense
2. Partial recompense

Closed without payment by reason of no:

1. Relevant coverage
2. Liability

The Company has written multiple lines of business in Oklahoma. The table below shows, for the examination period, the population of claims by line of business and the number of files randomly selected for review for this examination. Error ratios will be shown by coverage type, combining paid and denied.

TYPE	POPULATION	SELECTION
Health Claims Paid	112,905	100
Health Claims Denied	79,579	100
Dental Paid	5,335	100
Dental Denied	1,264	70

TYPE	POPULATION	SELECTION
Vision Paid EyeMed	6,262	100
OKC Credit Disb Paid	1,008	124
OKC Credit Disb Denied	20	20
OKC Credit Life Paid	199	50
OKC Credit Life Denied	19	19
OKC Life Paid	194	100
OKC Life Denied	4	4
OKC Accident Only Paid	504	100
OKC Accident Only Denied	136	47
OKC CA policy	201	41
	207,718	**975**

Life Claim Studies

Two (2) files out of the 104 OKC Life claims reviewed had timeliness errors for an error ratio of 1.9%.

Title 36 O.S. § 4030.1(A) states,
Within ten (10) days after an insurer receives written notification of the death of a person covered by a policy of life insurance, the insurer shall provide to the claimant the necessary forms to be completed to establish proof of the death of the insured and, if required by the policy, the interest of the claimant. If the policy contains a provision requiring surrender of the policy prior to settlement, the insurer shall include a written statement to that effect with the forms to be completed. Forms to establish proof of death and proof of the interest of the claimant shall be approved by the Insurance Commissioner.

The two (2) claims listed below are violations of the above code in that the proof of loss forms were not mailed out within ten (10) days of receipt of notice.

POLICY NO.	CLAIM NO.	NOTICE DATE	FORM MAILED	DAYS
B0002047	60995	12/12/2006	12/26/2006	14
BL0013949	60982	12/07/2006	12/20/2006	13

The Company said the person doing that job was new and missed the state deadline.

No other discrepancies were noted in this section of the examination.

Life Claims Handling

Of the 104 OKC Life Claims reviewed, all files were found to be in error for a 100% error ratio. The above code Section 4030.1 of Title 36 of the Oklahoma Statutes requires the..." Forms to establish proof of death and proof of the interest of the claimant shall be approved by the

Insurance Commissioner." The life claim form A355UICI has not been filed with the Commissioner. The Company has indicated that the filing process will be done immediately.

No other discrepancies were noted in this section of the examination.

Health Claims Time Studies

No discrepancies were noted in this section of the examination.

Health Claims Mandated Benefits

During the review of the selected claim files, errors were found in the payment or denial of benefits mandated by Sections 6058 through 6060.4 of Title 36 of the Oklahoma Statutes (Mandates). Investigation showed the errors were systemic and widespread. Further research and extensive interviews with Company personnel indicated that several of the Mandates have been misinterpreted and denied or underpaid by the Company. It appeared that some mammography claims were being paid at the $75 limit in effect at the time the policy was issued rather than the $115 limit in effect at the time of claim.

An electronic search was made of the claim database provided by the Company. Selected CPT (procedure) and ICDA (diagnostic) codes were used to identify potential problems. Since the raw numbers of potential mandate violations ran into the thousands, the examiners concentrated on one of the most widely paid mandates. A judgmental example of 920 claims for mammography expense that were paid for less than the mandated amount or denied altogether was given to the Company for further audit. While the Company showed 679 were paid or denied properly, they did agree 241 were not paid properly and needed to be readjudicated. This resulted in an error ratio of 26.2%. Detailed electronic search by the examiners was hampered by the unavailability of the CPT codes within some claims in the electronic data furnished. Full and proper identification of all mandate violations could not reasonably be accomplished within this examination.

The Company has agreed the Mandated benefits have not always been processed correctly and consistently. The adjustor may have assigned an incorrect "benefit code", the results of which would filter down through any additional rider under which that expense may be considered. The Obstetrical/Gynecological Examination benefit specifically requires that the mandated benefit shall in no way diminish or limit diagnostic benefits otherwise allowable. The Ambulatory Care Rider could provide for some of the expense of the Obstetrical/Gynecological Examination.
The Company, as a result of the discussions with the examiners', has felt it appropriate to begin a significant project of the review and enhancement of mandated benefit processing. The project will include:

- Evaluation and redefinition, where necessary, of the proper procedure for the application of each mandated benefit.
- Review of all mandated benefits in all states back to January 1, 2005 and readjudicate.

- The project will eventually provide for CPT and diagnosis code (as assigned by the provider) as the drivers for benefit determination, removing from the adjuster any subjective assignment of benefit codes.

Health Claims Handling

Within the 200 paid and denied Health claims reviewed, sixty-nine (69) errors were found for an error ratio of 34.5%. The errors are listed below.

— Title 36 O.S. § 1250.4(C) requires adequate response to communication from a claimant. Title 36 O.S. § 1250.5(1) requires disclosure of benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

The following twenty-two (22) claims had co-insurance deducted from proceeds, but the EOBs did not include any narrative or code explaining this to the payee or insured.

IL0970501	IJ8730901	GU0426701
EZ8919801	IP1855301	IX4436301
HE8610501	IK4146901	HJ3013301
FD2774101	HF7007601	FE7725701
HU5512201	GV8479401	HC1836601
IE8893101	HO6502601	GY1929601
GM9257401	IY8103601	HY9040801
	HA4455201	

— Additionally, the following forty-two (42) claims payment Explanation of Benefits (EOB) lacked sufficient information to identify what provision(s) of the base certificate or rider(s) were applied to calculate benefits. The information provided did not allow the reader to reconcile the calculation of the deductible amounts shown. Remark codes used on benefit maximums ask the reader to refer to the schedule of benefits page of the certificate for further information.

PAID DATE	BASE CLAIM NUMBERS	COMMENTS
03/01/2006	GF8306701	can't reconcile deductible
06/01/2006	GP9000601	can't reconcile deductible
04/22/2005	EY2356701, EY2356801	can't reconcile deductible
03/23/2005	EU5560101	can't reconcile deductible
05/20/2005	FA4021801	can't reconcile deductible
04/04/2007	HX9536401	can't reconcile deductible
10/16/2007	HK6622001, IU6801701	can't reconcile deductible
03/25/2005	ET5535201	can't reconcile deductible
05/23/2005	FB3484101	can't reconcile deductible

PAID DATE	BASE CLAIM NUMBERS	COMMENTS
04/29/2005	EN6507901	can't reconcile deductible
05/10/2005	FA2609701	can't reconcile deductible
02/13/2007	HQ5662001	can't reconcile deductible; refer to schedule
08/22/2007	IL4720701	can't reconcile deductible; refer to schedule
12/16/2005	FY2252501	refer to exclusions & limitations
11/05/2007	IW5411101	refer to rider; refer to schedule
01/30/2006	GB5216201	refer to schedule
03/17/2007	HV2982301	refer to schedule
04/24/2006	GM3924501	refer to schedule
11/14/2007	IC6830401, IY3780901	refer to schedule
05/12/2006	GN1856501	refer to schedule
07/23/2007	IK4074101, IK4074201	refer to schedule
06/13/2006	GR2144401	refer to schedule
02/14/2007	HR3734901	refer to schedule
09/21/2007	IR4716301	refer to schedule
04/18/2006	GL3026201	refer to schedule
01/11/2007	HN8185601	refer to schedule
08/31/2007	IO9372601	refer to schedule
12/20/2007	JB9018501, JB9018601	refer to schedule
08/24/2006	GY0532101	refer to schedule
11/27/2006	HH8891201	refer to schedule
09/08/2006	GT7420401, HB4580801	refer to schedule
03/02/2007	HS8798601	refer to schedule
08/21/2007	II9628101	refer to schedule
03/29/2007	HW9159101	refer to schedule
08/14/2007	IM2830501	refer to schedule
12/19/2006	HL2516801	refer to schedule
04/17/2006	GL0582301	refer to schedule
12/09/2005	FY0819001	refer to schedule
01/04/2007	HN2522901	refer to schedule
11/22/2006	HH6340301	refer to schedule
03/24/2006	GJ2776001	refer to schedule
08/28/2006	GY6758001	refer to schedule

— Five (5) claims for routine obstetrical/gynecological examinations were incorrectly denied in violation of Section 6060.3(a) of Title 36 of the Oklahoma Statutes. The claims and processing dates are listed below:

Process Date	Claim No
10/28/05	FT1856001
09/13/05	FN8089701
05/23/05	FB3267101
09/20/07	IQ7715701
04/05/06	GJ8569201

Credit Disability Claims

Of the 144 paid and denied Credit Disability claims two (2) errors were found for an error ratio of 1.4%. The errors are shown below.

— Title 36 O.S. §1250.4(C) requires and adequate response to communication from a claimant. The claims listed below, both processed by Life Assurance Co., Inc.(LAC), failed to identify the actual dates of the thirty (30) day elimination period imposed by the certificate in either the acknowledgment letter or the benefit check.

Policy No	Claim No	Process Date
205316	00013364	08/08/06
205390	00013586	07/11/07

During the examination, it was determined the claim on policy number 205390 was underpaid by $442.16. The policy, issued through LAC, had no indication as to the waiting period and whether it was an elimination or retroactive period. The Company has requested LAC to review all records and determine if other contracts need to be corrected.

Vision Claims

Of the 100 Vision claims handled by EyeMed nine (9) errors were found for an error ratio of 9%. The errors are listed below.

— Title 36 O.S. § 1250.4(A) requires that claim records be maintained in such detail that pertinent events and the dates of such events can be reconstructed. The EOBs were missing on the files listed below. EyeMed said that when the providers were no longer on the system the EOBs were not available. The files are listed below.

CLAIM NO.	BILL DATE	BILL AMOUNT
50744174224	08/09/05	$0.00
50744183681	08/09/05	$0.00
50744184651	08/09/05	$32.00
50744232969	08/09/05	$0.00
50744232978	08/09/05	$0.00
50744268662	08/09/05	$0.00
50744330847	08/25/05	$32.00
50747931270	12/08/05	$36.00
88883825460	04/11/07	$30.00

Dental Claims

— From a population of 6,599 paid and denied Dental Claims, 170 randomly selected files were reviewed. Two (2) files were not paid according to contract for an error ratio of 1.2%.

Claim number IF5167701 was denied in error because the previously prophylaxis was not done more that six (6) months prior to the date of service on the claim. The claim was readjudicated with a payment of $29.11 including interest.

Claim number HF8610401 was denied in error because the contract did not provide for a waiting period for class 1 preventative services that were rendered. The claim was readjudicated with a payment of $47.64 including interest.

When the above claims were pointed out, the Company not only corrected those files, but reviewed and found eight (8) additional claims, not within the sampling, that required readjudication and paid an additional $563.84 including interest.

No other discrepancies were noted in this section of the examination.

SUMMARY

Comments **Page(s)**

CONSUMER COMPLAINTS

Complaint Time Studies

Fifteen (15) inquiries were not responded to within the time allowed by Title 36 O.S. § 1250.4 (B) and (C), which resulted in an error ratio of 10.6% — 4-6

MARKETING AND SALES

Advertising

Thirty-four (34) items were submitted for review. Fourteen (14) errors were noted for an error ratio of 41%.

Twelve (12) violations of Code § 365:10-3-4, 365:10-3-5(a) and 365:10-3-6(C) as above. Regarding "24 hour coverage on or off the job." — 7

One (1) violation of Okla. Admin. Code § 365:10-3-5 regarding statements made by the association group about the insurance company. — 7-8

One (1) violation of Okla. Admin. Code § 365:10-3-5 in a presentation script for agents that made statements that would tend to mislead or deceive. — 8

PRODUCER LICENSING

Twenty-Five (25) licensing files showed violations of Section 1435.16 of Title 36 of the Oklahoma Statutes that requires timely notification of termination of appointment. These violations resulted in an error ratio of 86.2%. — 9

POLICY OWNER'S SERVICE

There were three (3) errors where the wrong non-forfeiture option was employed when premium payment ceased as required by Section 3610 of Title 36 of the Oklahoma Statutes. This resulted in a 4% error ratio. — 10

UNDERWRITING

Six (6) policy forms and their amendatory endorsements did not provide the mandated coverage for obstetrical/gynecological examinations as required by Section 6060.3(a) of Title 36 of the Oklahoma Statutes. 10-11

CLAIM PRACTICES

Life Claim Time Studies

Two (2) life claims did not have the proof of loss forms released within ten (10) days after receiving notice as required by Title 36 O.S. § 4030(1). 12

Health Claims Mandated Benefits

A judgmental example of 920 claims for mammography expense that were paid for less than the mandated amount or denied altogether was given to the Company for further audit. While the Company showed 679 were paid or denied properly, they did agree 241 were not paid properly and needed to be readjudicated. This resulted in an error ratio of 26.2%. 13-14

Life Claim Handling

There was a 100% error ratio of the 104 life claim files because none of the forms to establish proof of death had been approved as required by Title 36 O.S. § 4030(1). This is an error ratio of 1.9%. 12-13

Health Claims Handling

Title 36 O.S. §1250.4(C) requires and adequate response to communication from a claimant. Title 36 O.S. §1250.5(1) requires disclosure of benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim. See next two (2) items. The review of the health claims revealed sixty-nine (69) errors for an error ratio of 35.5% 14

Twenty-two (22) claims had errors in the EOBs for failure to show how co-insurance was applied to the claim. 14

Forty-two (42) claims had errors in the EOBs for failure to show how deductible amounts were applied. 14-15

Five (5) claims were not paid according to the mandate in Title 36 O.S. §6060.3(a) regarding obstetrical/gynecological examinations. 15

Two (2) credit disability claims had inadequate EOBs regarding how benefits were determined in violation of Title 36 O.S. § 1250.4 C. One (1) of these files was also underpaid. This produces an error ratio of 1.4% 16

Nine (9) EyeMed claims were incomplete in violation of Title 36 O.S. § 1250(4). This is an error ratio of 9%. 16

Two (2) Dental claims were not paid in accordance with contract provisions. 17

CONCLUSION

The market conduct examination report on The MEGA Life and Health Insurance Company is respectfully submitted to the Honorable Kim Holland, Insurance Commissioner of the State of Oklahoma.

Participation and assistance by Boyd A. (Tony) Higgins FLMI, CLU, ALHC, CIE, independent market conduct examiner, is gratefully acknowledged.

This examiner wishes to express his appreciation for the courteous cooperation and assistance given by the officers and employees of the Company during the course of this examination.

Sincerely,

Charles R. Pickett, MCM, CLU, ChFC, FLMI, CIE
Examiner-In-Charge, State of Oklahoma
Midwestern Zone III, NAIC

AFFIDAVIT

STATE OF FLORIDA.....)
)ss
COUNTY OF HILLSBOROUGH.....)

Charles R. Pickett, of lawful age, being first duly sworn, upon oath state that I have been charged with examining **The MEGA Life and Health Insurance Company as of December 31, 2007**, that I have prepared and read the foregoing Report of Market Conduct Examination, that I am familiar with the matters set forth therein, and I certify the Report is true and complete to the best of my knowledge and belief.

C Pickett
(SIGNATURE)

Subscribed and sworn to before me this 26 day of March 2009, by Charles R. Pickett.

NOTARY PUBLIC Susan J. Gunn

My Commission Expires: 7/24/2011

(SEAL)

SUSAN J GUNN
MY COMMISSION # DD663997
EXPIRES July 24, 2011
(407) 398-0153 FloridaNotaryService.com