REPORT ON EXAMINATION

of the

CARITEN INSURANCE COMPANY
1420 CENTERPOINT BLVD.
KNOXVILLE, TENNESSEE

as of

JUNE 30, 2008

DEPARTMENT OF COMMERCE AND INSURANCE

STATE OF TENNESSE

NASHVILLE, TENNESSE

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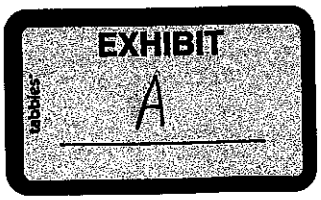
Dept. of Commerce & Insurance
Company Examinations



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Nashville, Tennessee
March 13, 2009

Honorable Leslie A. Newman
Commissioner
State of Tennessee
Department of Commerce and Insurance
Nashville, Tennessee 37243

Dear Commissioner:

Pursuant to your instructions and in accordance with Tennessee insurance laws, and regulations the Market Regulation Handbooks adopted by the National Association of Insurance Commissioners ("NAIC"), a market conduct examination was made of the condition of affairs of the

CARITEN INSURANCE COMPANY
1420 CENTERPOINT BOULEVARD
KNOXVILLE, TENNESSEE

hereinafter and generally referred to as the "Company," and a report thereon is submitted as follows:

INTRODUCTION

This examination was called by the Commissioner of Commerce and Insurance, state of Tennessee ("Commissioner") and commenced on November 19, 2008. The examination was conducted under the association plan of the NAIC by duly authorized representatives of the Department of Commerce and Insurance, state of Tennessee ("Department").

SCOPE OF THE EXAMINATION

This examination report covers the period from July 1, 2003 to the close of business June 30, 2008.

The examination of the market conduct condition was conducted in accordance with guidelines and procedures contained in the NAIC Market Conduct Examiners Handbook. During the course of the examination, procedure reviews accompanied by file reviews were utilized to determine policyholder equity as of June 30, 2008. Comprehensive tests reviewed Company operations, practices, and compliance with applicable statutes and regulations.

In addition, the following topics were reviewed:

Company History
Audit Functions
Marketing and Sales
Policyholder Services

A previous financial examination was conducted as of December 31, 2005, by authorized representatives of the Department.

One (1) recommendation was made regarding market conduct and policyholder equity from the financial examination.

1. The Company should implement a consistent system for responding to all grievances, including Department inquiries. This system should company with Tenn. Code Ann. § 56-51-131.

COMPANY HISTORY

The Company was incorporated as the National Burial Insurance Company, Memphis, Tennessee, on August 28, 1964, under the laws of the State of Tennessee. On September 12, 1977 the Company was purchased by Southern Affiliates, Inc., Knoxville, Tennessee. Southern Affiliates, Inc., subsequently changed its name to Bankers Affiliated Services, Inc, on October 13, 1977.

The Company has been acquired, sold, and undergone multiple charter changes since opening in 1964. On November 20, 1996 the Company shareholders voted to change the Company's name to Cariten Insurance Company. The name change amendment was approved by the Commissioner on November 27, 1996. The Company was acquired by Humana on October 31, 2008. The acquisition occurred outside of the examination scope; however, individuals from Humana expanded their roles throughout the examination process.

At June 30, 2008, the Company was licensed to transmit business only in the State of Tennessee. The Company engages in the sale of health products, including preferred provider organization and point-of-service products in the East Tennessee area.

MARKET CONDUCT ACTIVITIES

Operations and Management:

During the examination the Company was unable to provide a complete complaint/grievance register detailing 42 Department complaints and 9 forms of payment identification and declination. Failing to provide complete and accurate documentation is a violation of Tenn. Code Ann. § 56-1-409(b).

It is recommended that the Company establish a means to comply with Tenn. Code Ann. § 56-1-409(b) and make freely available all records upon request.

Complaint Handling:

The Company defines complaints as a verbal expression of dissatisfaction. A selection of complaints from the department were reviewed against Company records, presuming that Complaints would include both verbal and written complaints in accordance with Tenn. Code Ann. § 56-8-104(11).

The Company is unable to maintain a complete record of all complaints issued against the Company. The Company could not locate 42 complaints submitted by the Commissioner, a violation of Tenn. Code Ann. § 56-8-104(11). The Department provided two listings of complaints files, one at the onset and the other during the examination identified as "Cariten." Using the information provided, the Company was unable to identify which of the Cariten companies were responsible for the 42 mentioned complaints.

It is recommended that the Company comply with Tenn. Code Ann. § 56-8-104(11).

Producer Licensing:

The producer licensing review focused on two major areas; reconciling records between the Company and the Commissioner and determining if producers were properly appointed at the time of solicitation. Additionally, by statute any Company employee who assists in soliciting PPO and POS business and receives incentive based pay must also be appointed to the Company.

A review of producing licensing records was conducted to ensure that the Company is properly appointing agents in accordance with Tenn. Code Ann. § 56-6-115(c) and (h). Records received from the Company detailed six agents on the Company's listing which were not listed with the Commissioner. The Company was unable to provide documentation as to when these agents were appointed and are in violation of Tenn. Code Ann. § 56-6-115(c). Additionally, the Company having accepted applications, issuing policies and paying commissions to un-appointed agents is a violation Tenn. Code Ann. § 56-6-115(h).

It is recommended that the Company update and properly file all producer appointments to ensure compliance with Tenn. Code Ann. § 56-6-115(c). It is also recommended that the Company not accept applications, issue policies, or pay commissions to any agent broker unless they are properly appointed and in compliance with Tenn. Code Ann. § 56-6-115(h).

Underwriting:

The examiners selected a sample of 50 files from a population of 676 files issued by the Company during the examination period. Files were reviewed for compliance with

Tennessee laws and regulations including the use of properly approved policy forms and rates.

The policy review process included a review of policy forms to determine if the Company is in compliance with Tenn. Code Ann. § 56-26-102 (a), and utilizes policy forms which have been approved prior to use. Policy forms were selected from the 50 policy files selected for review. The Company issued 18% of the selected policies with forms which were not approved by the Commissioner when the policy was issued. The Company is in violation of Tenn. Code Ann § 56-26-102 (a). The 18% includes forms that the Company is unable to locate the approvals and have been deemed unfiled and in violation.

It is recommended that the Company comply with Tenn. Code Ann. § 56-26-102(a) by developing policies and procedures to track form approvals and ensure policies are not issued with unapproved forms.

Tenn. Code Ann. § 56-26-102(a) requires that rates be filed and approved prior to use. The examination team has been unable to verify the rates utilized by the Company comply with Tennessee laws and regulations. The Company utilizes complex rating modules that incorporate rating factors not included in the rate filings submitted to the Department for approval.

It is recommended that the Company comply with Tenn. Code Ann. § 56-26-102(a).

Paid Claims:

The examination's comprehensive scope was predicated on determination of the Company's prompt pay compliance with Tenn. Code Ann. § 56-7-109. Review standards focused on communication, investigation, resolution, documentation, and handling within policy provisions. The paid claims review consisted of reviewing 100 paid claims from a population of 4,248,224 claims received during the examination period. Claims were reviewed to determine if the claim was considered clean or unclean, if the claim was paid timely and if all documentation was presented. Consideration was given for statutory timeframe allowances for both electronic and paper claims.

The review of the paid claims showed that 16% of sampled population claimants were not notified timely of unclean claims. Three (3) claims were paper claims in violation of Tenn. Code Ann § 56-7-109(b)(1)(A)(iii) for failing to notify the claimant that the claim unclean within thirty (30) days. Thirteen (13) electronic claims in violation of Tenn. Code Ann §56-7-109(b)(1)(B)(iii) for failing to notify the claimant that the claim was unclean within twenty-one (21) days.

The paid claim population was tested to determine prompt pay compliance with Tenn. Code Ann § 56-7-109. The table below details by year the percentage of claims both paper and electronically and the percentage paid promptly.

Cariten Insurance Company Electronically Reported Claims Paid within 21 Days of Reported Date		Cariten Insurance Company Paper Reported Claims Paid within 30 Days of Reported Date	
Year Reported	Percent Response	Year Reported	Percent Response
2003	88.65%	2003	89.95%
2004	89.61%	2004	91.41%
2005	81.57%	2005	92.73%
2006	83.38%	2006	87.47%
2007	86.08%	2007	85.14%
2008	87.40%	2008	85.47%

It is recommended that the Company develop a plan to properly ensure that all unclean claims are handled in accordance with Tenn. Code Ann. § 56-7-109.

The review of the paid claims showed that 16% of sampled population was not paid according to prompt pay standards. Three (3) claims were paper claims in violation of Tenn. Code Ann § 56-7-109(b)(1)(A) for failing to pay the claimant within thirty (30) days. Thirteen (13) electronic claims in violation of Tenn. Code Ann. §56-7-109(b)(1)(B) for failing to pay the claimant within twenty-one (21) days.

It is recommended that the Company develop a comprehensive plan to properly address and pay/deny all claims whether paper or electronic within statutory timeframes for Tenn. Code Ann. § 56-7-109 compliance.

Denied Claims:

The denied claims sample consisted of 100 claims out of a population of 978,054 denied during the examination period. Claims were reviewed to determine if the claim was considered clean or unclean, if the claim was denied timely, if the claim was denied after performing a complete investigation and if all documentation was presented. Additionally, consideration was given for statutory timeframe allowances for both electronic and paper claims.

The review of the denied claims showed that 21% of sampled population claimants were not notified timely of unclean claims. Eight (8) claims were paper claims in violation of Tenn. Code Ann. § 56-7-109(b)(1)(A)(iii) for failing to notify the claimant that the claim unclean within thirty (30) days. Thirteen (13) electronic claims in violation of Tenn. Code Ann. §56-7-109(b)(1)(B)(iii) for failing to notify the claimant that the claim was unclean within twenty-one (21) days.

Many of the cleanness determination delays were based upon the Company's attempt to recoup prior claim payments. The Company failed to notify the claimants of their recoupment intent which violates Tenn. Code Ann § 56-7-110(g)(6). Additionally the

denied claims were based upon unapproved contractual changes related to reimbursements, which must be provided 30 days prior to use according to Tenn. Code Ann. § 56-7-1013.

It is recommended that the Company develop a plan to properly ensure that all unclean claims are properly addressed in accordance with Tenn. Code Ann. § 56-7-109.

The review of the denied claims showed that 21% of sampled population was not denied according to prompt pay standards. Eight (8) claims were paper claims in violation of Tenn. Code Ann. § 56-7-109(b)(1)(A) for failing to deny the claimant within thirty (30) days. Thirteen (13) electronic claims in violation of Tenn. Code Ann. §56-7-109(b)(1)(B) for failing to deny the claimant within twenty-one (21) days.

It is recommended that the Company comply with Tenn. Code Ann. § 56-7-109. Also, see the paid claim findings for additional recommendations.

Grievances

The examiners reviewed 100 grievances from a population of 7,843 grievances received during the examination period. Grievance files were reviewed to determine if the Company held reviews within 10 working days of receipt, requested additional time to review when required, and finalized their review within 10 working days if additional time was required.

The examiners found that the Company failed to properly respond to all grievances in all 100 or 100% of the tested population. There was no identification of the Company holding reviews of the grievance within 10 working days, no requests for extension, and no resolution or response within 10 working days.

Additionally, the examiners found no evidence of the Company's follow-up on the previous examination finding that; "The Company should implement a consistent system for responding to all grievances, including Department inquiries. This system should comply with Tenn. Code Ann. § 56-51-131." The Company failed to follow up on this recommendation.

- ***It is recommended that the Company comply with the previous examination's Grievance recommendations.***

COMMENTS AND RECOMMENDATIONS

COMMENTS:

- As noted in the previous examination and the within the Grievance section about the Company the Company remains in violation of Tenn. Code Ann. § 56-32-110(c)(5).

RECOMMENDATIONS:

- ***It is recommended that the Company establish a means to comply with Tenn. Code Ann. § 56-1-409(b) and make freely available all records upon request.***

- ***It is recommended that the Company comply with Tenn. Code Ann. § 56-8-104(11).***

- ***It is recommended that the Company update and properly file all producer appointments to ensure compliance with Tenn. Code Ann. § 56-6-115(c). It is also recommended that the Company not accept applications, issue policies, or pay commissions to any agent broker unless they are properly appointed and in compliance with Tenn. Code Ann. § 56-6-115(h).***

- ***It is recommended that the Company comply with Tenn. Code Ann. § 56-26-102(a) by developing policies and procedures to track form approvals and ensure policies are not issued with unapproved forms.***

- ***It is recommended that the Company comply with Tenn. Code Ann. § 56-26-102(a).***

- ***It is recommended that the Company develop a plan to properly ensure that all unclean claims are handled in accordance with Tenn. Code Ann. § 56-7-109.***

- ***It is recommended that the Company develop a comprehensive plan to properly address and pay/deny all claims whether paper or electronic within statutory timeframes for Tenn. Code Ann. § 56-7-109 compliance.***

- ***It is recommended that the Company develop a plan to properly ensure that all unclean claims are properly addressed in accordance with Tenn. Code Ann. § 56-7-109.***

- ***It is recommended that the Company comply with Tenn. Code Ann. § 56-7-109. Also, see the paid claim findings for additional recommendations.***

- ***It is recommended that the Company comply with the previous examination's Grievance recommendations***

CONCLUSION

Insurance examination practices and procedures, as promulgated by the NAIC and the Commissioner have been followed in connection with the verification and valuation of the policyholder equity of Cariten Insurance Company of Knoxville, Tennessee.

In such a manner, it was determined, as of June 30, 2008, the Company has numerous areas where policyholder treatment violates Tennessee law. Violations were found in numerous areas including how the Company handles complaints and grievances, compliance with producer licensing and appointment requirements, promptly pay requirements, policy form approval and rate compliance. Corrective action taken in accordance with recommendations contained in this examination report will allow the company to address those areas of non-compliance.

The courteous cooperation of the officers and employees of the Company extended during the examination is hereby acknowledged.

Respectfully submitted,

Derek R. Stepp, C.I.E, M.C.M
Insurance Examiner
State of Tennessee

AFFIDAVIT

The undersigned deposes and says that he has duly executed the attached examination report of Cariten Insurance Company dates March 13, 2009, and made as of June 30, 2008, on behalf of The Department of Commerce and Insurance, State of Tennessee. Deponent further says he is familiar with such instrument and the contents thereof, and the facts therein set forth are true to the best of his knowledge, information and belief.

Derek R. Stepp, C.I.E, M.C.M
Insurance Examiner
State of Tennessee

Cariten Healthcare
a HUMANA affiliate

Cariten Health Plan • Cariten Insurance Company • Cariten TPA Services
HMO • POS • PPO • EAP • Workers' Compensation

January 20, 2011

Department of Commerce and Insurance
Horace E. Gaddis, Jr., CFE
500 James Robertson Parkway
Nashville, Tennessee

Re: Response to Report on Market Conduct Examination of
Cariten Insurance Company

Dear Mr. Geddis,

Please find Cariten Insurance Company's responses to your recommendations for the Market Conduct Examination received on December 27th, 2010 below.

We are specifically rebutting the Grievance recommendation referring to regulation 56-51-102. Please see our rebuttal under grievances. We have included information in our responses indicating we submitted information to the auditors that appears was not taken into consideration.

There will be no membership on Cariten Insurance Company as of March 1st, 2011. All members will roll to Humana entities. At that time, all processes will be conducted according to Humana's Policies & Procedures.

If you have any question, please contact me at 770-350-2157 or e-mail at jthorsen@humana.com.

Sincerely,

Joan Thorsen/CS

Joan Thorsen
Regulatory Compliance Director

EXHIBIT
B

Market Conduct Activities

Operations and Management

Recommendation-Pg 4

It is recommended that the Company establish a means to comply with Tenn. Code 56-1-409(b) and make feely available all records upon request.

Response

Cariten utilizes the UMAD database to document complaints from the Tennessee Department of Commerce and Insurance (TDCI). UMAD is used to log and track all complaints from the TDCI. Reports from the UMAD database indicate the due date of the TDCI complaint, number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. These and any other records will be made available upon request by the Commissioner

Complaint Handling

Recommendation-Pg 5

It is recommended that the Company comply with Tenn Code Ann. 56-8-104(11).

Response:

Cariten utilizes the UMAD database to document complaints from the Tennessee Department of Commerce and Insurance (TDCI). UMAD is used to log and track all complaints from the TDCI. Reports from the UMAD database indicate the due date of the TDCI complaint, number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. These and any other records will be made available upon request.by the Commissioner

Please see Attachment #1- TDCI Complaint Tracking

Producer Licensing:

Recommendation-Pg 5

It is recommended that the Company update and properly file all producer appointments to ensure compliance with Tenn. Code Ann. 56-6-115(c). It is also recommended that the Company not accept applications, issue policies, or pay commissions to any agent broker unless they are properly appointed and in compliance with Tenn. Code Ann. 56-6-115(h)

Response

Humana Agency Management has taken over the process to appoint agents for Cariten legal entities after the exam period. Our department has a process in place to file TN appointments for agents at time of contract or application submission. Agency Management has a systematic process in place to validate agent appointment information prior to the issue of commission's payments.

Please see attachment # 2

Underwriting

Recommendation-Pg 6

It is recommended that the Company comply with Tenn. Code ann. 56-26-102(a) by developing policies and procedure to track form approvals and ensure policies are not issued with unapproved forms.

Response

Humana validates that before any changes are made to certificate language, that we file those changes with the TN DOI via SERFF and wait for DOI approval before implementing that revised language into our policy and certificate forms that are distributed to our members. We work with many internal business partners as well as the TN DOI to maintain compliance with TN laws and regulations.

Please see Attachments #3 and #3a

Recommendation-Pg 6

It is recommended that the Company comply with Tenn. Code Ann. 56-26-102(a)

Response
Going forward, all existing Cariten Insurance Company business will be migrated to Humana products. As such, any rate filings submitted on behalf of Humana Health Plan and Humana Insurance Company will be applicable to this acquired business.

Large Group
Since its acquisition of the Cariten Insurance Company, no rate filings have been submitted on Humana's 100+ employee group pricing model for products tied to a Humana insurance legal entity. Humana uses an experience rating methodology for the 100+ employee group block of business. The regulation 56-26-102(a) states that in the case of experience-rated group insurance, we do not have to file but the information must be maintained by the insurance company and made available for review by the commissioner upon the commissioner's request. Humana has the experience-rated group insurance, premium rates and classifications of risks available for review by the commissioner upon request.

Small Group

SB Actuarial Response:

Humana Insurance Company files a premium rate manual for all 2-99 products to accompany any new form filings submitted to the Tennessee Department of Commerce and Insurance in compliance with Tennessee Code 56-26-102(a). These premium rates, and any following revisions made, are not inadequate, excessive, unfairly discriminatory, or unreasonable in relation to benefit provided. Like all filings submitted on behalf of Humana Health Plan, an Actuarial Memorandum accompanies all Humana Insurance Company rate filings in which a qualified actuary certifies that reasonable actuarial assumptions have been used to determine the appropriateness of the charges.

Humana Insurance Company completes Annual Certifications for Small Group Business in which a qualified actuary certifies that rating practices comply with state regulations and that the rating methods are actuarially sound.

<u>Paid Claims-Pg 7</u>

Recommendation

It is recommended that the Company develop a plan to properly ensure that all unclean claims are handled in accordance with Tenn. Code Ann. 56-7-109

Response

Auditors included adjusted claims in their findings. Rebuttals were provided at the time of the examination to the reviewers.

In accordance Cariten Insurance Company processes paper claims within 30 calendar days of the receipt date and pays electronic claims within 21 days of receipt date. The payer system is set-up to adjudicate clean and unclean claims submitted. If an unclean claim is processed and there are lines that will pay and lines that will deny, the Provider will receive an EOP (Explanation of Payment) that shows the lines that have paid and gives the Provider an explanation of the services that were denied and what needs to be submitted back to have the services paid. Please see Policy and Procedure which is attached and titled "Non-clean claim" defined and "Clean claim defined."

Please see attachment 4 and 4a

Recommendation-Pg 7

It is recommended that the Company develop a comprehensive plan to properly address and pay/deny all claims whether paper or electronic within statutory timeframes for Tenn. Code Ann. 56-7-109 compliance.

Response

Rebuttals were provided at the time of the examination to the reviewers in the form of documentation.

In accordance Cariten Insurance Company processes paper claims within 30 calendar days of the receipt date and pays electronic claims within 21 days of receipt date. The payer system is set-up to adjudicate clean and unclean claims submitted. Please see Policy and Procedure which is attached and titled "Non-clean claim" defined and "Clean claim defined."

Please see attachment 4 and 4a

<u>Denied Claims</u>

Recommendation-Pg 8

It is recommended that the Company develop a plan to properly ensure that all unclean claims are properly addressed in accordance with Tenn. Code Ann. 56-7-109.

Response

All EOB's and EOP's that were requested by the auditors were sent to them showing the timeliness of processing the unclean claims. There was one EOB and/or EOP that could not be found.

In accordance Cariten Insurance Company processes paper claims within 30 calendar days of the receipt date and pays electronic claims within 21 days of receipt date. The payer system is set-up to adjudicate clean and unclean claims submitted. If a unclean claim is processed and there are lines that will pay and lines that will deny, the Provider will receive an EOP (Explanation of Payment) that shows the lines that have paid and gives the Provider an explanation of the services that were denied and what needs to be submitted back to have the services paid. Please see Policy and Procedure which is attached and titled "Non-clean claim" defined and "Clean claim defined."

Please see attachment 4 and 4a

Recommendation-Pg 8

It is recommended that the Company comply with Tenn. Code Ann. 56-7-109. Also, see the paid claim findings for additional recommendations

Response

Once the claim is opened and adjusted the auditors were going back to the original date the claim was received. That is not correct. The timeframe for adjusted claims is from the date the claim was reopened.

In accordance Cariten Insurance Company recoups claims as follows:

1. Underpayments-Cariten will correct provider underpayments when the provider requests such correction within eighteen (18) months of the date the provider was paid. Providers shall not be required to appeal errors in payments when the claim has not been paid according to contracted rates. When notice of a provider underpayment is received timely, Cariten shall correct and pay the underpayment within thirty (30) calendar days of receipt of any necessary documentation verifying the underpayment. Cariten will not correct provider underpayments when a provider requests the payment correction more than eighteen (18) months after the claim was paid
2. Overpayments-Cariten may retroactively deny a claim and furnish a provider with notice within eighteen (18) months after Cariten paid the claim to which the overpayment applies. Credit balances may be held indefinitely. If overpayment is due to the provider's fraud, the limitations shall not apply.
3. Collecting Overpayments.-Cariten may collect overpayments by withholding or offsetting the overpayment amount against current or future payments to the provider or by requesting a refund for the amount overpaid from the provider.

Notice Requirements. The notice to the provider must be written or electronically transmitted and must contain (i) the basis for the denial; (ii) amount of the overpayment; (iii) the patient's name and insurance/HMO coverage; (iv) the patient identification number; (v) the date of service; (vi) the service to which the overpayment applies; and (vii) a description of pending claims against which the overpayment will be offset or a statement that the overpayment will be offset against future claims payments. Cariten provides the notice the form of an Explanation of Payment (EOP) mailed to the provider (and Negative Balance History report if applicable) at the time the claim is adjusted through the normal claims payment process. For policy on above please see attachment titled "Correcting Provider underpayments and recouping provider overpayments".

Please see Attachment 4b

Grievances

Recommendation-Pg 8

It is recommended that the Company comply with the previous examination's Grievance recommendations.

Rebuttal:

The code 56-51-102 that refers to 56-32-110(c)(5) is for Prepaid Health Systems plans as identified in the TDCI regulation below and does not apply to Cariten Insurance Company.
"Prepaid limited health service organization" means any person, corporation, partnership, or any other entity that, in return for a prepayment from a health maintenance organization or a state or federal agency, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. A "prepaid limited health service organization" may not contract with individuals, but only through a health maintenance organization or a state or federal agency. This shall not limit the organization from contracting with providers to provide contracted services. "Prepaid limited health service organization" does not include:

(A) An entity otherwise authorized pursuant to the laws of this state to indemnify for any limited khealth service;

(B) A provider or entity when providing limited health services pursuant to a contract with a prepaid limited health service organization, a health maintenance organization, a health insurer, or a self-insurance plan; or

(C) Any person who, in exchange for fees, dues, charges or other consideration, provides access to a limited health service provider without assuming any responsibility for payment for the limited health service or any portion of the limited health service;

Response
For the PPO product, Cariten has 60 days from receipt of an appeal to complete the appeal process.

Cariten Insurance Company utilizes the UMAD data base which maintains written documentation regarding all appeals.

Cariten Insurance Company will accept and process any oral or written grievance from a member (including representative or provider) expressing dissatisfaction with any aspect of the plan that has not been previously resolved to the satisfaction of the member. An acknowledgement letter is issued within five business days of receipt of the grievance. The Grievance Coordinator will research the grievance and consult with the appropriate departments for resolution of the grievance. Cariten Insurance Company has thirty (30) calendar days from receipt to resolve a grievance. Cariten Insurance Company uses written procedures for receiving and resolving grievances/appeals.

The attached Grievance/Appeal Policies and Procedures follow ERISA Regulations

Please see attachments #5, and #5b-Commercial Appeal P&P and Commercial Grievance P&P