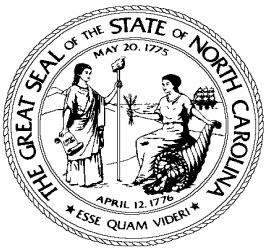

Report on

Market Conduct Examination

of

Aetna Health Inc.

Blue Bell, Pennsylvania

by Representatives of the

North Carolina Department of Insurance

as of

March 27, 2015

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Raleigh, North Carolina
March 27, 2015

Honorable Wayne Goodwin
Commissioner of Insurance
Department of Insurance
State of North Carolina
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Raleigh, North Carolina 27603

Honorable Teresa D. Miller
Acting Commissioner
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Honorable Commissioners:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134 and 58-67-100, a general examination has been made of the market conduct activities of the Health Maintenance Organization (HMO)

Aetna Health Inc.
(NAIC #95109)
NAIC Exam Tracking System Exam Number: NC299-M54
Blue Bell, Pennsylvania

hereinafter generally referred to as the Company, at the Company's office located at 2801 Slater Road, Suite 200, Morrisville, NC 27560 and at the North Carolina Department of Insurance (Department) office located at 11 S. Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The North Carolina Department of Insurance conducted a general examination of the Company. The examination commenced on April 28, 2014, and covered the period of January 1, 2012, through December 31, 2013, with analyses of certain operations of the Company being conducted through March 23, 2015. Review of the Company's general administration activities covered the period of January 1, 2009, through December 31, 2013. All comments made in this report reflect conditions observed during the period of examination.

The examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of the examination included a review of the Company's practices and procedures in general administration, provider relations and delivery system, utilization management, quality management, provider credentialing, claims practices, policyholder treatment, underwriting practices, and delegated oversight.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/non-compliance at or above the following levels: 0 percent for grievances and the use of contract forms that were neither filed with nor approved by the Department; 7 percent for claims practices; and 10 percent for all other areas reviewed.

EXECUTIVE SUMMARY

This market conduct examination revealed concerns with Company procedures and practices in the following areas:

General Administration – Failure to provide the data year 2012 NC Managed Care Annual Filing by the required due date; and failure to provide written notice to the Department regarding applications made in other states for licensure as an HMO.

Provider Relations and Delivery System – Failure to provide a portion of the requested provider and facility contract files for the Department's review.

Utilization Management – Failure to provide timely medical necessity and member appeal review acknowledgements and determinations.

Provider Credentialing – Failure to conduct timely facility re-credentialing activities; and failure to provide written notification documentation for the Department's review regarding providers excluded from the network.

Policyholder Treatment – Failure to send timely member grievance acknowledgement letters; failure to send compliant grievance determination letters; and failure to hold the review panel meeting for a second-level grievance within the required timeframe.

Underwriting Practices – Failure to use a rating factor most recently approved by the Department; failure to use correct group size rating factors; failure to consistently document an employer group's effective date; and selling to an employer group located in a county in which the Company is not licensed to do business.

Delegated Oversight – Executing provider contracts prior to the Department's approval; failure of intermediaries to utilize provider contracts, which contained required statutory provisions; failure to provide an initial intermediary certification and notice of contract termination for an intermediary; failure to receive (or receive timely) quarterly updated provider lists from intermediary and contract organizations; and failure to conduct ongoing monitoring of provider contracts utilized by six intermediaries.

Specific violations are noted in the appropriate section of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com by clicking "INSURANCE DIVISIONS" then "Legislative Services".

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations. Examination report findings that do not reference specific insurance laws, regulations, or bulletins are presented to improve the Company's practices and provide consumer protection.

COMPANY OVERVIEW

History and Profile

The Company was issued its license from the North Carolina Department of Insurance on March 31, 2010, and is domiciled in Blue Bell, Pennsylvania. The Company is licensed in 22 states. The Company commenced HMO operations in Pennsylvania beginning in 1987. In March 2002, the Company changed its name from United States Health Care Systems of Pennsylvania, Inc. to Aetna Health of Pennsylvania, Inc. and then to Aetna Health Inc. in May 2002. The Company offers HMO and POS products to both small and large groups in 42 North Carolina counties.

GENERAL ADMINISTRATION

The Company's general administration documentation and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. Review of this section of the examination covered the period of January 1, 2009, through December 31, 2013.

The review revealed that the Company did not adhere to the provisions of NCGS 58-3-191 as the NC Managed Care Annual Filing for data year 2012 was not received at the Department by the required due date of May 1, 2013. It was received on May 14, 2013.

Required Written Notice

The Company did not provide written notice to the Department regarding applications made in other states for licensure as an HMO; therefore, did not adhere to the provisions of 11 NCAC 20.0602(3). The applications for HMO licensure made by the Company are listed as follows:

- Arizona – April 1, 2009
- Colorado – March 9, 2010
- District of Columbia – September 30, 2009
- Delaware – November 5, 2009
- Illinois – June 3, 2009
- Kansas – December 21, 2009

- Maryland – December 2, 2009
- Missouri – October 13, 2009
- Nevada – April 17, 2009
- Oklahoma – March 3, 2009
- South Carolina – October 1, 2009
- Tennessee – March 27, 2009
- Virginia – December 21, 2009

PROVIDER RELATIONS AND DELIVERY SYSTEM

The Company's provider relations and delivery system activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The contracting and provider services area develops, expands, and maintains provider networks; educates participating providers; resolves provider issues; and retains provider contracts and other records.

Provider Contract Files

One hundred provider contract files were randomly selected for review from a population of 10,002. The contracts were reviewed to determine adherence to Company guidelines and compliance with North Carolina statutes and regulations. Two files were determined to be outside of the examination timeframe; therefore, the sample size was reduced to 98. The review revealed that the Company did not adhere to the provisions of 11 NCAC 19.0102, 19.0106, and 20.0304, as the Company was unable to produce the provider contracts for 13 files (13.3 percent error ratio).

Facility Contract Files

Fifty facility contract files were randomly selected for review from a population of 373. The contracts were reviewed to determine adherence to Company guidelines and compliance with North Carolina statutes and regulations. Three files were determined to be outside of the examination timeframe; therefore, the sample size was reduced to 47. The review revealed that the Company was unable to produce the facility contracts for four files (8.5 percent error ratio).

Network Availability and Accessibility Standards

The Company's standards for provider and facility availability and accessibility, as well as monitoring results showing performance against these standards were reviewed. The review revealed that the Company adhered to the provisions of 11 NCAC 20.0300(3).

UTILIZATION MANAGEMENT

The Company's Utilization Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

As required by the provisions of NCGS 58-50-61, a formal structure has been established to oversee and conduct utilization management functions. The Aetna HCM (Health care Management) Regional Medical Director has ultimate responsibility for oversight and implementation of the regional Aetna Care Management Program. This department is integrated with other operational areas of the Company in accordance with the provisions of NCGS 58-50-61.

Telephone Access

Aetna Patient Management, National Precertification, National Medical Excellence (NME), Beginning Right Maternity Program, and Behavioral Health staff are available 24 hours a day through a toll-free telephone line for provider and member inquiries for specific utilization management issues. Member calls initially directed to Member Services requesting information about specific utilization issues beyond a coverage determination are forwarded to the applicable area for handling in adherence to the provisions of NCGS 58-50-61(e)(3). Standards for telephone accessibility have also been established in adherence to the provisions of NCGS 58-50-61(e)(3). The Company did not meet its average speed of answer standard for the year 2012 with the exception of the months of May and June. In addition, they did not meet the abandonment rate with the exception of the months of May, June, July, and September. In 2013, the Company did not meet its average speed of answer for the entire year. In addition, it

did not meet the abandonment rate standard with the exception of the months of May and July. The standards and actual performance are outlined in the following chart:

Performance Measure	Company Standard	Actual Performance	
		2012	2013
Average speed of answer (seconds)	≤ 30.0	111.4	117.0
Abandonment rate (%)	≤ 2.0	4.6	6.5

Medical Necessity Reviews

The scope of utilization management services provided includes: prospective review for hospital admissions and ambulatory care and services; concurrent review of inpatient health services; and retrospective review for referral management, complex case management, and discharge planning.

The Company handles emergency notification in adherence to the provisions of NCGS 58-3-190, which require that the health plan not condition coverage of emergency care upon the member's notification of the receipt of such services.

Noncertifications are communicated to members in adherence to the provisions of NCGS 58-50-61. The notification includes all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification.

A. Prospective Records Review

The Company completed a total of 693 prospective review requests during the examination period. A random sample of 50 prospective review files was examined. Within three files (6.0 percent error ratio), the determination was not communicated within three business days after receiving all necessary information. Therefore, the Company did not adhere to the provisions of NCGS 58-50-61(f).

B. Concurrent Records Review

The Company completed a total of 824 concurrent review requests during the examination period. A random sample of 50 concurrent review files was examined. Within four files (8.0 percent error ratio), the determination was not communicated within three business days after receiving all necessary information. Therefore, the Company did not adhere to the provisions of NCGS 58-50-61(f).

C. Retrospective Records Review

The Company completed a total of 71 retrospective review requests during the examination period. A random sample of 50 retrospective review files was examined. Within one file (2.0 percent error ratio), the determination was not communicated within 30 days after receiving all necessary information. Therefore, the Company did not adhere to the provisions of NCGS 58-50-61(g).

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of his/her appeal if a delay in rendering health care would be detrimental to his/her health.

Appeal Records Review

The Company received a total of 68 member appeals during the examination period. A random sample of 50 appeal files were reviewed to assess the Company's timeliness and adherence to the provisions of NCGS 58-50-61 and 58-50-62, as well as the Company's adherence to its own policies and procedures. The following issues were noted, therefore, the Company did not adhere to the provisions of NCGS 58-50-61:

- In 20 files (40.0 percent error ratio), the Company did not send the acknowledgement letter within three business days of receipt;
- In four files (8.0 percent error ratio), the acknowledgment was not sent to the insured;

- In two files (4.0 percent error ratio), the resolution and written notification to the insured was not completed in 30 days of receipt;
- In two files (4.0 percent error ratio), the second-level appeal review panel meeting notification letter was not sent to the insured at least 15 days prior to hearing date.

The average service time to process a first-level member appeal was 20 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	2.0
8 - 14	20	40.0
15 - 21	17	34.0
22 - 30	9	18.0
Over 60	3	6.0
Total	**50**	**100.0**

QUALITY MANAGEMENT

The Company's Quality Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Quality Management Plan

The Company has adopted a written quality management plan in accordance with the provisions of 11 NCAC 20.0503. Established policies and procedures guide the staff in plan implementation. The policies address conflict of interest situations and confidentiality of member health information in accordance with the provisions of 11 NCAC 20.0508 and 20.0509. The Company has evaluated its quality management program annually as required by the provisions of 11 NCAC 20.0511.

Quality of Care Grievances

There were no quality of care grievances received by the Company during the examination period.

PROVIDER CREDENTIALING

The Company's provider credentialing activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Department Structure and General Operations

The Company has a program to verify that its network providers are credentialed before the Company lists those providers in its provider directory in adherence to the provisions of 11 NCAC 20.0303 and 20.0401. The credentialing program includes provisions for credentialing and re-credentialing a variety of providers. The Company has adopted a written credentialing plan that contains policies and procedures to support the credentialing program in adherence to the provisions of 11 NCAC 20.0403. The credentialing plan, policies, procedures, checklists, and other documents used by the credentialing staff include all required provisions outlined in 11 NCAC 20.0400.

Provider Credentialing Files

One hundred provider credentialing files were randomly selected for review from a population of 10,002. The review revealed that all files adhered to the provisions of 11 NCAC 20.0400. No adverse trends or unfair trade practices were observed in this section of the exam.

Facility Credentialing Files

Fifty facility credentialing files were randomly selected for review from a population of 373. The review revealed that in ten files (20.0 percent error ratio), the Company had not conducted re-credentialing activities every three years, therefore, did not adhere to the provisions of 11 NCAC 20.0407.

Network Excluded Providers

The Department reviewed the total population of 43 rejected/excluded provider files for adherence to the Company's guidelines and to the provisions of 11 NCAC 20.0405(d), which requires the Company to provide written notice to the applicant of the determination within specified time frames. The review revealed that in 43 files (100.0 percent error ratio), the

Company was unable to provide any written notification information. Therefore, the Company did not adhere to the provisions of 11 NCAC 20.0405(d).

CLAIMS PRACTICES

The Company's claims practices were reviewed to determine compliance with the appropriate North Carolina statutes and rules and adherence to the Company's own policy provisions. The review encompassed paid and denied claims.

Paid Claims Sample Review

One hundred paid claim files were randomly selected for review from a population of 576,812. The claim files were reviewed to determine compliance with the provisions of NCGS 58-3-225. The review revealed that three claims (3.0 percent error ratio), were processed beyond 30 days of receipt. The Company paid the applicable interest for these claims at the time of adjudication, in adherence with the provisions of NCGS 58-3-225(e).

The average service time to process a claim payment was ten calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	59	59.0
8 - 14	23	23.0
15 - 21	6	6.0
22 - 30	8	8.0
31 - 60	4	4.0
Total	**100**	**100.0**

Denied Claims Sample Review

One hundred denied claim files were randomly selected for review from a population of 136,839. The claim files were reviewed to determine compliance with the provisions of NCGS 58-3-225. The review revealed that five claims (5.0 percent error ratio), involved processing errors which resulted in improper denials. The Department instructed the Company to reprocess the claims. Additional claims payments totaled $214.41. Two of the claims involved

lab work ordered by a participating physician from a non-participating laboratory. The Department informed the Company that the contracted physicians should receive provider education regarding participating lab utilization.

In addition, one partially denied claim (1.0 percent error ratio), was processed beyond 30 days of receipt. The Company paid the applicable interest for the claim at the time of adjudication, in adherence with the provisions of NCGS 58-3-225(e).

The average service time to process a claim denial was nine calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	62	62.0
8 - 14	14	14.0
15 - 21	10	10.0
22 - 30	13	13.0
31 - 60	1	1.0
Total	**100**	**100.0**

Claims Processing Standards

The Company's standards for claims processing accuracy and timeliness, as well as its actual performance during the examination period, are outlined in the following chart:

Performance Measure	2012		2013	
	Standard (%)	Actual (%)	Standard (%)	Actual (%)
Overall Accuracy	95.0	98.9	95.0	98.9
Timeliness: within 10 days	80.0	95.2	80.0	94.9
Timeliness: within 30 days	98.0	98.7	98.0	98.4

The examiners noted that the Company did not meet the standard for 'timeliness within 30 days' during the month of May 2013.

POLICYHOLDER TREATMENT

The Company's policyholder treatment activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Member Grievance Procedures

The Company has policies and procedures in place that adhere to the provisions of NCGS 58-50-62 for handling and responding to member grievances.

Member Grievances Sample Review

Fifty member grievance files were randomly selected for review from a population of 231. The grievance files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-62 based on the following:

- In 34 files (68.0 percent error ratio), the acknowledgement letter was either not sent or was sent beyond three business days of receiving the grievance.
- Six files (12.0 percent error ratio), contained a noncompliant determination letter, as the letters did not reference either MCPAP or Health Insurance SmartNC as applicable based on the date of the letter.

Seven first-level grievance files within the sample were escalated to second-level grievance reviews. Review of the files revealed that the Company did not adhere to the provisions of NCGS 58-50-62 based on the following findings:

- In one file (2.0 percent error ratio), no acknowledgement letter was sent.
- In one file (2.0 percent error ratio), the second-level grievance review panel meeting was not held within 45 days after receiving the second-level grievance request.

The average service time to process a first-level member grievance was 15 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	14	28.0
8 - 14	13	26.0
15 - 21	7	14.0
22 - 30	16	32.0
Total	**50**	**100.0**

UNDERWRITING PRACTICES

The Company's premium rate setting and underwriting activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Employer Group Underwriting

Fifty employer group underwriting files were randomly selected for review from a population of 958. All 50 files contained initial and renewal information. Included in the sample were 46 small employer groups, and four large employer groups.

Review of the sample files revealed that the Company did not adhere to the provisions of 11 NCAC 19.0104, 19.0106, NCGS 58-67-10, and/or NCGS 58-67-50 as follows:

- In two files (4.0 percent error ratio), the Company failed to utilize the most recently approved rate filing to calculate the premium rates which resulted in overcharges to the employer group. Upon the Department's instruction, the Company issued refunds to the policyholders, totaling $345.14, and submitted applicable documentation.

- In one file (2.0 percent error ratio), the Company documented two different standard industry codes for the employer group. The correct code was used to calculate the premium rates.

- In one file (2.0 percent error ratio), the Company utilized an incorrect group size factor, which resulted in an undercharge to the employer group.

- In one file (2.0 percent error ratio), the Company utilized an incorrect group size factor, which resulted in an overcharge to the employer group. No refund was warranted in this case due to non-payment of premium.

- In one file (2.0 percent error ratio), the Company sold business to an employer group located in a county where it is not licensed to do business.

- In one file (2.0 percent error ratio), the Company consistently failed to document the employer group's effective date.

DELEGATED OVERSIGHT

The Company's delegated oversight activities and obligations were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Intermediary Contracts and Management Agreements

Review of the Company's executed contracts with delegated entities and intermediaries revealed that the Company did not adhere to the provisions of NCGS 58-67-30, 11 NCAC 20.0201, and/or 11 NCAC 20.0204 as the Company executed contracts prior to the Department's approval as follows:

- The intermediary agreement with ChoiceHealth, Inc. was executed on May 21, 2004, which was prior to the Department's January 1, 2010 approval.
- The delegated credentialing agreement with Eye America, IPA was executed on June 17, 2002, and had not been approved by the Department.
- The delegated call center agreement with EyeMed Vision Care, LLC was executed on June 20, 2006, which was prior to the Department's October 15, 2010 approval.
- The delegated credentialing agreement with EyeMed Vision Care, LLC was executed on June 15, 2006, which was prior to the Department's June 29, 2010 approval.
- The national delegated claims agreement with First American Administrators, Inc. was executed on June 15, 2006, which was prior to the Department's June 29, 2010.
- The intermediary agreement with EyeMed Vision Care, LLC was executed on June 13, 2006, which was prior to the Department's March 14, 2012 approval.
- The management agreement with MedSolutions, Inc. for the provision of utilization management services was executed on January 1, 2007, which was prior to the Department's May 14, 2007 approval.
- The delegated credentialing agreement with WakeMed Faculty Physicians was executed on March 15, 2006, which was prior to the Department's November 17, 2009 approval.
- The delegated credentialing agreement with UNC Hospitals was executed on March 16, 1998, which was prior to the Department's March 9, 2010 approval.
- Aetna Health Management, LLC executed a Pharmacy Benefit Management Subcontract Agreement with Caremark PCS Health, LLC on July 27, 2010, which was prior to the Department's December 10, 2010 approval.

In addition, the Company did not adhere to the provisions of 11 NCAC 20.0204 and Bulletin 97-B-1 as it did not submit the initial intermediary certification for OptumHealth Care Solutions, Inc. for the provision of chiropractic services. The regulatory provisions require the

Company to submit the initial certification to the Department at the time the Company enters into a relationship with an intermediary.

The Company did not adhere to the provisions of NCGS 58-50-270, 58-50-275, 58-50-280, and 58-50-285 as provider contracts utilized during the examination period by the following intermediaries did not include the required statutory provisions:

- Choice Health
- EyeMed
- Four Counties Physicians Association, Inc.
- Key Physicians, PA
- Lake Norman Regional Medical Center
- OptumHealth Care Solutions, Inc. (PT/OT)
- OptumHealth Care Solutions, Inc. (Chiropractic)
- Eye America (2012 only)

The Company did not adhere to the provisions of 11 NCAC 20.0601(d) as it terminated its contract with Eye America, IPA on May 10, 2012, and did not provide the required notice of termination to the Department. In addition, the Company did not adhere to the provisions of 11 NCAC 19.0102(a) and 19.0106(c)(3) as it could not provide an executed copy of its intermediary agreement with Eye America, IPA.

Review of Actual Monitoring and Oversight

A review was made of the Company's oversight and monitoring of all intermediary and other contracted entities performing delegated functions. The Company did not adhere to the provisions of 11 NCAC 20.0410(2) as it did not receive quarterly updated provider lists (or did not receive the lists timely) from the following intermediaries or contract organizations to which it delegated credentialing activities:

- Choice Health – the Department could not determine receipt date for the first quarter 2012 update.

- Lake Norman Regional Medical Center – there was no first quarter update for 2012; and could not ascertain receipt date for the first quarter 2013 update.

- EyeMed – there were no first and third quarter updates for 2012 and 2013.

- OptumHealth Care Solutions, Inc. – could not ascertain when two provider updates were received.

- UNC – there were no updates for the first, second, and third quarters for 2012.

- Duke University Health Systems – there was no third quarter 2012 update; and there were no second and fourth quarter 2013 updates.

- Wake Forest University – the fourth quarter 2012 update was received late as it was received on February 27, 2013, and the previous quarter's submission had been received October 11, 2012; there was no second quarter 2013 update; and could not ascertain receipt dates for the third and fourth quarter 2013 updates.

- WakeMed – the third quarter 2012 update was received late as it was received October 8, 2012, the previous quarter's submission had been received on April 3, 2012; and the second quarter 2013 update was received on June 10, 2013, which was a late submission as the previous quarter's update had been received on January 8, 2013.

- Managed Health Resources – the fourth quarter 2012 update was received on March 13, 2013, which was a late submission.

The Company did not adhere to the provisions of 11 NCAC 20.0202 and 20.0204. During the examination period it did not conduct ongoing monitoring of provider contracts utilized by its six intermediaries to ensure compliance with the regulatory requirements.

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must submit the NC Managed Care Annual Filing to the Department by the required due date each year, as well as, provide written notice to the Department regarding applications made in other states for licensure. The Company must also provide timely medical necessity and member appeal review acknowledgements and determinations to members and timely member grievance acknowledgement letters, as well as, compliant grievance determination letters. The Company must hold the review panel meeting for a second-level grievance within the required timeframe. The Company must provide complete provider and facility contract files for the Department's examination, provide written notification for the

Department's review regarding providers excluded from the network, as well as, conduct timely facility re-credentialing activities. The Company must use correct group size rating factors, as well as, factors most recently approved by the Department. Additionally, the Company must consistently document an employer group's effective date and sell to employer groups located only in those counties in which the Company is licensed to do business. The Company must receive timely quarterly updated provider lists from intermediary and contract organizations, as well as, conduct ongoing monitoring of provider contracts utilized by intermediaries. The Company must execute provider contracts which have been approved by the Department and its intermediaries must utilize provider contracts, which contain required statutory provisions. Additionally, the Company must provide initial intermediary certifications and notice of contract termination for intermediaries to the Department.

CONCLUSION

A general examination has been conducted on the market conduct affairs of Aetna Health Inc. for the period of January 1, 2012, through December 31, 2013, with analyses of certain operations of the Company being conducted through March 23, 2015. Review of the Company's general administration activities covered the period of January 1, 2009, through December 31, 2013.

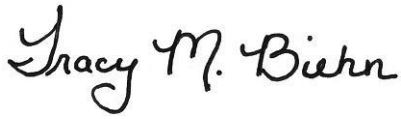
The examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of general administration, provider relations and delivery system, utilization management, quality management, provider credentialing, claims practices, policyholder treatment, underwriting practices, and delegated oversight.

In addition to the undersigned, Jill H. Dale, PAHM, HIA, MHP, and Tanyelle Byrd, MBA, MHA, North Carolina Market Regulation Examiners, and Lalita Wells, JD, CPM, AIAA, ACS, Assistant Chief Examiner participated in this examination and the preparation of this report.

Respectfully submitted,

Scott D. Grindstaff, HIA, MHP
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.



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