THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

4 Ever Life Insurance Company

Oakbrook Terrace, IL

For the Period January 1, 2022, through December 31, 2022

NAIC COMPANY CODE: 80985

EMPLOYER ID NUMBER: 36-2149353

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COMMISSIONER

December 8, 2025

The Honorable Michael T. Caljouw
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One Federal Street, Suite 700
Boston, Massachusetts 02110-2012

Dear Commissioner Caljouw:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, the Massachusetts Division of Insurance ("Division") has performed a limited-scope market conduct examination ("Continuum of Regulatory Options/Interrogatory") of the market conduct affairs of **4 Ever Life Insurance Company** ("Company"). The examination included but was not limited to the Company's 2022 calendar year health insurance business in Massachusetts.

The Company's home office:

2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL, USA 60181

The following report thereon is respectfully submitted.

ACRONYMS

The Better Business Bureau ("BBB")
Behavioral Health ("BH")
Blue Cross Blue Shield of Massachusetts ("BCBSMA" or "Blue Cross")
INS Regulatory Insurance Services, Inc. ("INS")
Massachusetts Attorney General's Office ("AGO")
Massachusetts Division of Insurance ("Division")
Market Conduct Annual Statement ("MCAS")
Market Regulation Handbook ("MRH" or "the Handbook")
Medical/Surgical ("M/S")
Mental Health ("MH")
National Association of Insurance Commissioners ("NAIC")
Non-Quantitative Treatment Limitation ("NQTL")
Obstetrics and Gynecology ("OB-GYN")
Office of Patient Protection ("OPP")
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")
Pharmacy Benefit Managers ("PBMs")
Quantitative Treatment Limitation ("QTL")
Substance Use Disorder ("SUD")
System for Electronic Rate Form Filing ("SERFF")
Third-Party Administrators ("TPAs")
United States of America ("USA")

BACKGROUND

On or about July 2023, the Massachusetts Division of Insurance ("Division") commenced a behavioral health parity compliance market conduct examination, pursuant to section 8K of Chapter 26 of the Massachusetts General Laws as amended by Chapter 177 of the Acts of 2022 (An Act Addressing Barriers to Care for Mental Health), section 4 of Chapter 175, section 10 of Chapter 176G and all other applicable statutes. Following the legislative mandate, the limited scope examination focused primarily but not exclusively on compliance with the applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MPHAEA"), as amended, any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a) (3), and applicable state mental health parity laws, including, but not limited to, section 47B of Chapter 175, section 8A of Chapter 176A, section 4A of Chapter 176B and sections 4, 4B and 4M of Chapter 176G.

The examination included an Interrogatory as provided under the Continuum of Regulatory Options ("Continuum") for market conduct examinations. The Continuum focused the examination on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/ reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA, and denials of payment and coverage. In addition, the examiners reviewed the Market Conduct Annual Statement ("MCAS"), National Association of Insurance Commissioners ("NAIC") financial filings, and Massachusetts health binder filings within the System for Electronic Rate and Form Filing ("SERFF"). In addition, for those companies that received a report from the Massachusetts Attorney General's Office ("AGO") in 2020, the examiners conducted an evaluation of

the Company responses.

INS Regulatory Insurance Services, Inc. ("INS"), a consultant qualified to perform market analysis and market conduct examinations under the management and general direction of the Division, conducted the limited scope examination described in the preceding paragraphs.

SCOPE OF EXAMINATION

The examination was initiated with an interrogatory, one of the options outlined in the Continuum of Options section of the NAIC Market Regulation Handbook ("MRH" or "the Handbook"). The interrogatory focused on MHPAEA compliance in key areas, including utilization review, step therapy, network admission standards, network adequacy, denials of payment and coverage, quantitative treatment limitations, and the policies and procedures used to monitor compliance within the Company and with third-party administrators and vendors. Additionally, the interrogatory inquired about the methods employed to ensure the accuracy of the 2022 Health MCAS filed by the Company. The examiners used sources, including the Company responses, the MCAS filing, and existing reports within the Division, to assess the accuracy and completeness of Company-reported data.

EXAMINATION APPROACH

The examination employed the guidance and standards in the 2022 Handbook, the examination standards of the Division, the Commonwealth of Massachusetts' insurance laws, regulations, bulletins, and applicable federal laws and regulations. Examiners performed all procedures under the supervision of the Division's market conduct examination staff.

The Handbook provides guidance on optional processes and procedures for use during the examination and includes an approach designed to detect potential areas of non-compliance. The methodology outlined in the Handbook identifies key practices and controls used to operate the business and to meet essential business objectives, including measures designed to ensure compliance with applicable MHPAEA state and federal laws and regulations.

All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify improper or non-compliant business practices does not constitute acceptance of such practices. The Company shall report to the Division on any such corrective actions taken.

Interested parties can review all Massachusetts laws, regulations, and bulletins cited in this report on the Division's website at http://www.mass.gov/doi.

EXECUTIVE SUMMARY

This summary provides a high-level overview of the examination results, while the remainder of the text summarizes all observations, conclusions, recommendations, and corrective actions required as a result of the examination.

Required Company Corrective Action:

Policies and Procedures Related to Claim Denials

Examination Conclusions: The Company submitted documentation from the administrator, Geo Blue, who processes claims and claim denials. The Company must require vendors to develop denial processes and procedures that eliminate the need for manual workarounds. The Company is continuing to work with its vendors to better document, claim denial processes, and procedures applicable to mental health/substance use disorder ("MH/SUD") complaints. The Company stated it rarely has claims for MH/SUD. The Company understands that it must have MH/SUD denial policies and procedures in place to ensure that claims processing is not more stringent for MH/SUD than for medical/surgical ("M/S"), which is imperative to verifying compliance with MHPAEA.

Corrective Action: Based on the review, the examiners found that the Company lacks formalized policies and procedures for claims processing, including denials, that meet MHPAEA regulatory requirements. The revised procedures must be sufficient to enable the Company to monitor all phases of claims processing, ensuring that the practices ensure parity for MH/SUD claimants with MS claimants. The Company must submit a report to the Division's Market Conduct Section on or before February 12, 2026, detailing the revised practices and procedures and demonstrating how the revisions ensure compliance with the MHPAEA and related statutes, regulations, and bulletins.

Policies and Procedures Compliance with Federal Requirements on Provider Data Accuracy

Examination Conclusions: The Company and BCBSMA are collaborating to develop a system that enables the Company to verify its (own) provider's data independently quarterly. In the interim, BCBSMA currently has network measures in place that enable the Company to use the BCBSMA network for the Company's Massachusetts network. Based on the review of the BCBSMA's Company's practices related to network adequacy, the examiners have determined that the Company is in compliance with federal requirements governing the accuracy of provider data.

Corrective Action: The Company should request reports from BCBSMA's network adequacy for Massachusetts provider data accuracy quarterly and should continue to pursue the system that enables the Company to verify its (own) provider's data independently on a quarterly basis.

Reimbursement Rate Policies

Examination Conclusions: The Company's response included general information about rates, accompanied by a chart illustrating reimbursements for international and domestic providers. This information falls short of the required practices and procedures necessary to meet regulatory requirements, allowing examiners to verify any difference between the reimbursement rates for M/S and BH providers. The Company reported that it is in discussions with its vendor, BCBSMA, to determine if there are any differences between reimbursement rates for M/S and BH providers. The Company did provide the NQTL documentation from BCBSMA related to reimbursement rates. The narrative did include language that there are no differences between reimbursement rates for M/S and MH/SUD providers.

Corrective Action: The Company should be prepared to provide examples of calculations on future exams and if requested by the Division of Insurance.

Quantitative Treatment Limitations

Examination Conclusions: Based on the review of the quantitative treatment limitation ("QTL") testing, the Company anticipates it will be compliant going forward. The Company responded that it would add

the details for substantially all testing prior to the predominant testing with a pass or fail indication from this point forward. The Company did provide a more recent example of non-quantitative treatment limitation ("NQTL") analysis; however, there was no documentation for QTL testing documentation provided.

Corrective Action: The Company did not provide QTL analysis indicating whether the substantially all testing was conducted prior to the predominant testing and a pass/fail indication. The Company must submit a report to the Division's Market Conduct Section on or before February 12, 2026, detailing the revised QTL testing. The Company should demonstrate that the substantially all testing is conducted prior to the predominant testing and include indicators for pass/fail.

I. COMPLAINTS/GRIEVANCES

Closed Consumer Complaints

The interrogatory requested a summary log of all closed consumer complaints submitted by consumers directly to the Company from January 1, 2022, through December 31, 2022. This log included any closed complaints submitted to the Division, the Massachusetts Office of the Attorney General ("AGO"), the Better Business Bureau ("BBB"), MyPatientsRights.org, and the Office of Patient Protection ("OPP").

Examination Procedures Performed: Typically, INS reviews the complaint summary log for MHPAEA compliance and identified complaints and grievances related to potential network adequacy insufficiencies. INS also inquires whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviews the Company's complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviews the Company's complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviews the Company's complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviews the Company's complaint/grievance registers to identify any trends related to consumers having to pay out-of-network rates due to a lack of in-network providers,
e) inquires if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Company, and
f) reviews to determine the final number of complaints and identify those that were of potential concern.

As the Company did not have consumer complaints during the examination period, the above procedures were minimized to only verifying policies and procedures.

Examination Conclusions: The Company had no consumer complaints during the examination review period. The Company does have policies and procedures in place to ensure that complaints from internal/external vendors are captured and reported. Based on the review of the complaint/grievance policies and procedures, the Company's complaint and grievance procedures meet Massachusetts statutory and regulatory requirements.

There were 0 total number of consumer complaints, and 0 were of potential concern.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted by consumers directly to the Company from January 1, 2022, through December 31, 2022. This log included any closed complaints submitted to the Division, the AGO, the BBB, MyPatientsRights.org, and the OPP.

Examination Procedures Performed: Typically, INS reviews the summary log for MHPAEA compliance and identified any complaints/grievances related to potential network adequacy insufficiencies. In addition, INS inquires whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviews the Company's complaint/grievance registers to identify whether there were sufficient in-network providers.

b) reviews the Company's complaint/grievance registers to identify whether there was a lack of in-network providers for M/S, MH, and SUD.
c) reviews the Company's complaint/grievance registers to identify whether there were trends for out-of-network denials.
d) reviews the Company's complaint/grievance registers to identify trends related to consumers having to pay out-of-network rates due to a lack of in-network providers.
e) inquires if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Company, and
f) reviews to determine the final number of complaints and identify those of potential concern.

As the Company did not have consumer complaints during the examination period, the above procedures were minimized to only verifying policies and procedures.

Examination Conclusions: The Company had zero reported provider complaints during the examination review period. The Company has policies and procedures in place to ensure that complaints from internal/external vendors are captured and reported. Based on the review of the complaint/grievance policies and procedures, the Company's complaint/grievance procedures meet Massachusetts' statutory and regulatory requirements.

There were 0 total number of consumer complaints, and 0 were of potential concern.

II. MARKET CONDUCT ANNUAL STATEMENT

Companies with $50,000 or more in yearly premium sales in certain lines of business must file the MCAS report annually. The companies were asked to verify the accuracy of their MCAS data or, if they had not filed MCAS, to supply the information contained in the MCAS to the examiners. The examiners verified with the Company that they attested to the accuracy of the data.

Examination Procedures Performed: INS reviewed the MCAS fields related to prior authorizations (pharmacy and excluding pharmacy), and external review data for both in-exchange and out-of-exchange. Further, INS:

a) developed statewide averages for each field for both in-exchange and out-of-exchange,
b) reviewed all prior authorization denials for non-pharmacy and pharmacy and compared the state data to the statewide medians and averages,
c) reviewed the percentage of MH/SUD prior authorization denials to see if they were higher than M/S prior authorization denials,
d) reviewed the consumer-requested external reviews (excluding pharmacy) that were overturned, and,
e) verified that addenda were filed about the accuracy of the MCAS data.

Examination Conclusions: The Company did not submit the MCAS data to the NAIC but provided the data manually in accordance with the examination request. The Division did discuss the MCAS filing issue with the Company on April 30, 2025. The Company does not need to file MCAS data due to a recent clarification from the NAIC that expatriate plans are exempt.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

The companies supplied the names of the internal and external third-party administrators ("TPAs") involved in claims processing. For this review, the request focused on any TPAs directly involved in claims processing, including those administrators who accept, deny, or otherwise adjudicate the claims. For example, the request might include pharmacy benefit managers ("PBMs"), administrators that process M/S and MH/SUD claims, and administrators that may process international claims. The list of requested TPAs should include those processing M/S claims, as well as those involved in MH/SUD claims processing. The examiners reviewed the response to identify which providers are used and for what purpose.

Examination Procedures Performed: INS reviewed the third-party entities involved with claims processing. Further, INS identified whether:

a) M/S claims are processed through a different vendor than those processing claims for MH/SUD,
b) a vendor (within the Company group or an outside vendor) is used for pharmacy claims, and
c) whether a PBM is utilized.

Examination Conclusions: The Company provided a list of all third-party entities involved in claim determinations and identified the type of claims that each third-party processes. This response was complete and sufficient.

Policies and Procedures Related to Claim Denials

Examination Procedures Performed: INS reviewed the third-party policies and procedures for claim denials. Further, INS also identified whether:

a) the Company has adequate processes and procedures for claims processing,
b) if the Company writes in multiple jurisdictions, the policies and procedures for claims denials must include information about state-specific requirements,
c) the state-specific addendums have been reviewed to determine if all addendums are up to date with any recent bulletins, statutes, regulations, or related recent amendments or revisions, and
d) the information provided was adequate to determine if the individual at the Company making the denial decision is experienced in the area they are reviewing. Ideally, the individual should be board-certified in the area being reviewed (e.g., psychologist/board-certified, behavior analyst-doctoral, and/or a psychologist with clinical experience).

Examination Conclusions: According to the information provided by the Company there are four third-party entities involved in claims handling and their respective claims processing documents. The Company submitted documentation from the administrator, Geo Blue, who processes claims and claim denials. The Company must require vendors to develop denial processes and procedures that eliminate the need for manual workarounds. The Company continues to work with its vendors, GeoBlue and Magellan Healthcare Inc., to improve documentation of claim denial processes and procedures applicable to MH/SUD claims. The Company stated it rarely has claims for MH/SUD. The Company understands that it must have MH/SUD denial policies and procedures in place to ensure that claims processing is not more stringent for MH/SUD than for M/S, which is imperative to verifying compliance with MHPAEA.

Corrective Action: Based on the review, the examiners found that the Company lacks formalized policies and procedures for claims processing, including denials, that meet MHPAEA regulatory requirements.

The revised procedures must be sufficient to enable the Company to monitor all phases of claims processing, ensuring that the practices ensure parity for MH/SUD claimants with MS claimants. The Company must submit a report to the Division's Market Conduct Section on or before February 12, 2026, detailing the revised practices and procedures and demonstrating how the revisions ensure compliance with the MHPAEA and related statutes, regulations, and bulletins.

M/S, MH and SUD Claims Received, Paid, Denied (in part or in whole)

Examination Procedures Performed: The Company provided the claims received, paid, denied in part, and denied in whole, separated by M/S, MH, and SUD. The examiner totaled the data and created statewide averages and medians to determine if companies were outliers. Further, INS identified whether:

a) the claims paid were less than statewide averages and medians,
b) the percentage of total denials was over the statewide averages and medians,
c) the denials for M/S claims were higher than statewide averages and medians,
d) the denials for M/H claims were higher than statewide averages and medians,
e) the denials for SUD claims were higher than statewide averages and medians, and
f) the denials of MH and SUD claims were higher than M/S claim denials.

Examination Conclusions: The Company provided data for claims received, paid, and denied. The examiners noted that the Company did not include any denied claims for SUD. The Company verified the accuracy of the data regarding the absence of denied SUD claims. The Company has reviewed this book of business in other states and found that expatriate health plans traditionally have very low usage of SUD services. Employers conduct health examinations, testing, and screenings before they hire employees to work internationally on assignments. Based on the review of the claims received, paid, and denied, the Company meets Massachusetts statutory and regulatory requirements.

IV. NETWORK ADEQUACY

The Companies were asked to supply processes and procedures to demonstrate their compliance with the state and federal requirements for network adequacy. The Company were also asked to provide a listing of their MHPAEA plans. The examiners selected a plan from the Company's list and performed a search on the Company website, searching for an Obstetrics and Gynecology ("OB-GYN") provider and a MH or SUD provider.

Policies and Procedures Compliance with Federal Requirements on Provider Data Accuracy

Examination Procedures Performed: INS reviewed the Company's policies and procedures to determine if the Company complied with federal requirements on provider data accuracy. The purpose of the INS review was:

a) to ensure the Company had documented policies and procedures,
b) to ensure compliance with the No Surprises Act (42 USCS § 300gg-115) for all provider types and
c) to confirm that the accuracy of provider data is reviewed every 90 days.

Examination Conclusions: The Company and BCBSMA are collaborating to develop a system that enables the Company to verify its (own) provider's data independently quarterly. In the interim, BCBSMA currently has network measures in place that enable the Company to use the BCBSMA network for the Company's Massachusetts network and they provide a quarterly provider data reports to 4 Ever Life

Insurance Company. Based on the review of the BCBSMA's practices related to network adequacy, the examiners have determined that the Company is in compliance with federal requirements governing the accuracy of provider data.

Observation: The Company should request reports from BCBSMA's network adequacy for Massachusetts provider data accuracy quarterly and should continue to pursue the system that enables the Company to verify its (own) provider's data independently on a quarterly basis.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Company's response to verify that the list of plans subject to the mental health parity requirement in 2022 was provided to the Division. Further, INS reviewed the Company's response to verify:

a) the Company responded to the question, and
b) the list provided matches the 2022 SERFF Filing Binder (if applicable).

Examination Conclusions: Based on the review of the plans supplied by the Company, the response is sufficient and accurate.

Basic Web Searches

Examination Procedures Performed:
The examiners selected a plan from the Company's list and performed a search on the Company website searching for an OB-GYN provider and a MH or SUD provider. Further, INS:

a) conducted a basic search without a login to find an OB-GYN within the plans service area,
b) conducted a basic search without a login to find an MH/SUD provider,
c) confirmed that the name of the plan displayed on the website was consistent with the Company name provided, and
d) reported challenges encountered in the search to the Company.

Examination Conclusions: No concerns were identified based on the review of the Company's website.

V. NETWORK ADMISSION STANDARDS

The Company supplied the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review.

Network Admission Standards Policies/Procedures Data Submitted

Examination Procedures Performed: INS reviewed the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review to determine if ample processes and procedures were in place. Further, INS considered:

a) if any additional barriers exist that make it harder for MH/SUD providers to become a member of the network,

b) if the Company is using a TPA or another vendor for MH/SUD. If the Company have processes in place for the vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply,
c) if there are differences between MH/SUD and M/S admission processes, evaluate the differences to ensure they do not result in more stringent or have extra requirements for MH/SUD applicants. (For example, what are the liability insurance requirements for M/S versus MH/SUD?)

Examination Conclusions: The vendor, BCBSMA, required 24-hour coverage by a Blue Cross credentialed provider for all behavioral health practitioners, but only for a few physicians and nurses on the medical-surgical side. This requirement is a more stringent network admission standard on MH/SUD than the standards imposed on M/S. The Company responded that BCBSMA no longer mandates 24-hour coverage as a credentialing requirement for behavioral health practitioners, effective April 8, 2025. Based on the review of the network admission standards, the Company's network admission standards now meet Massachusetts statutory and regulatory requirements.

Reimbursement Rate Policies

Examination Procedures Performed: INS reviewed the reimbursement rate policies and procedures. Further, INS reviewed the reimbursement rate policies to:

a) ensure the rate policies were complete and detailed,
b) verify whether a third-party or internal entity handles the reimbursement rate policies, and
c) verify the reimbursement procedures/methods are not more stringent for MH/SUD than for M/S providers. (Additional software, etc.)

Examination Conclusions: The Company's response included general information about rates, accompanied by a chart illustrating reimbursements for international and domestic providers. This information falls short of the required practices and procedures necessary to meet regulatory requirements, allowing examiners to verify any difference between the reimbursement rates for M/S and BH providers. The Company reported that it is in discussions with its vendor, BCBSMA, to determine if there are any differences between reimbursement rates for M/S and BH providers. The Company did provide the NQTL documentation from BCBSMA related to reimbursement rates. The narrative did include language that there are no differences between reimbursement rates for M/S and MH/SUD providers.

Corrective Action: The Company should be prepared to provide examples of calculations on future exams and if requested by the Division of Insurance.

Number of Network Admissions During the Period (M/S, MH and SUD)

Examination Procedures Performed: INS reviewed the network admissions for the examination period. Further, INS reviewed the data to ensure:

a) the information was separated into M/S and MH/SUD,
b) the information included facilities for M/S and MH/SUD,
c) the reasons for denial were included, and
d) the percentage of denials for MH/SUD was similar to those for M/S.

Examination Conclusions: The vendor, BCBSMA, provided a list of admissions to the network. It was noted that 29.7% of M/S applicants and 35.5% of MH/SUD providers were ineligible for credentialing. Of the total applicants, 68.8% of M/S applicants were accepted into the network, while 64.4% of the

MH/SUD applicants were accepted to the network. The examiners requested that the Company obtain an explanation from BCBSMA regarding the higher percentages of MH/SUD network admissions that are ineligible for credential review and the lower acceptance rate compared to M/S applicants.

BCBSMA explained that the term "ineligible for credentialing review" may describe a situation ("case") where the application is incomplete and therefore could not be reviewed by the Credentialing and Peer Review department for acceptance into the network. BCBSMA also explained that one applicant could have multiple applications pending due to entry errors in submitting the application. The Company elaborated that MH/SUD providers are more likely to be individual providers without practice support or access to health system credential support functions, so they may need assistance and additional follow-up. BCBSMA further reported that MH/SUD and M/S have the same acceptance rates, with MH/SUD actually 1% higher than M/S.

Based on the review of the network admissions, the Company's network admissions meet Massachusetts statutory and regulatory requirements.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

Examination Procedures Performed: The companies supplied policies, procedures, and documentation to show the implementation of MHPAEA compliance. Further, INS reviewed the data to:

a) ensure the Company has policies and procedures for ensuring compliance with MHPAEA,
b) ensure the Company monitors/audits vendors for compliance and,
c) ensure the Company has an organized compliance plan for MHPAEA oversight.

Examination Conclusions: The Company initially provided only a high-level summary of its compliance plan for MHPAEA compliance. However, they later provided current policy and procedures documentation entitled "Mental Health Parity Compliance." Based on the review, the Company meets Massachusetts statutory and regulatory requirements regarding compliance with MHPAEA.

VII. QUANTITATIVE TREATMENT LIMITATIONS

The Company must demonstrate that QTL testing was conducted with indicators for pass/fail.

Examination Procedures Performed: The examiners reviewed the data to determine if the QTL testing was complete. Further, INS reviewed the data to:

a) ensure the Company provided testing results (pass/fail),
b) verify if the Company reported fail in any one or multiple categories,
c) verify if the QTL analysis included the substantially all testing,
d) verify if the QTL analysis includes predominant testing, and
e) verify if the Company demonstrated that the substantially all testing (2/3 threshold) was completed before the predominant testing.

Examination Conclusions: Based on the review of the QTL testing, the Company anticipates being compliant going forward. The Company responded that it would add the details for substantially all testing prior to the predominant testing with a pass or fail indication from this point forward. The Company provided a more recent example of NQTL analysis; however, there was no documentation for QTL.

Corrective Action: The Company did not provide QTL analysis indicating whether the substantially all testing was conducted prior to the predominant testing and a pass/fail indication. The Company must submit a report to the Division's Market Conduct Section on or before February 12, 2026, detailing the revised QTL testing. The Company should demonstrate that the substantially all testing is conducted prior to the predominant testing and include indicators for pass/fail.

VIII. STEP THERAPY

The Company submitted the step-therapy requirements, the number of step-therapy requests and how many were approved, denied in part, or denied in whole.

List of M/S, MH/SUD and Pharmacy Benefits Requiring Step-Therapy

Examination Procedures Performed: The examiners reviewed the data to determine if the step-therapy or fail first requirements distinguished between M/S, MH/SUD, and pharmacy. Further, INS reviewed the data to:

a) ensure the Company provided step-therapy documentation,
b) verify the Company provided step-therapy for both M/S and MH/SUD,
c) identify if any MH/SUD medications should not require step-therapy (e.g., smoking cessation) and,
d) determine if all medications within a particular class of MH/SUD medications, including generic versions, require step therapy.

Examination Conclusions: There are no fail-first options within the plan. The plan does include some high-priced drugs that may require prior authorization and may require a medical necessity review. This is not a problem unless an entire class of medications requires prior authorization and/or medical necessity review. The Company should continue to monitor its list of medications to ensure that an entire class of medications does not require prior authorization or extra medical necessity review documentation. (It may be helpful for physicians if the prior authorization documentation includes a list of other medications to try first.) Based on the review of the M/S, MH/SUD, and pharmacy benefits requiring step-therapy, the Company meets Massachusetts statutory and regulatory requirements.

Number of Step-Therapy Requests, Approved, Denied (in part or in whole)

Examination Procedures Performed: The examiners reviewed the data to determine the number of approved, partially denied, or fully denied step-therapy requests that were completed during the examination period. Further, INS reviewed the data to:

a) determine statewide averages and medians for approvals, partial denials, and whole denials,
b) determine if the Company had higher averages and medians than the statewide averages, and,
c) identify if the number/percentages of denials and partial denials are higher for MH and SUD as compared to M/S.

Examination Conclusions: Based on the review of the number of the two medical/surgical and four prescription step-therapy requests approved, denied (in part or in whole), the Company complies with Massachusetts statutory and regulatory requirements. There were no step therapy requests pertaining to behavioral health.

IX. UTILIZATION REVIEW

The Company was requested to provide the TPAs for MH/SUD, the medical necessity guidelines criteria, and the sources for those guidelines. In addition, the Company was requested to provide the M/S, M/H, and SUD requests separated by approved, denied in part, and denied in whole, further classified by prior authorization, concurrent review, and retrospective review.

Third-Party Administrators and Medical Necessity Claim Determinations

Examination Procedures Performed: The examiners reviewed the list of third-party administrators provided by the Company. Further, INS reviewed the data to verify if:

a) the list included all TPAs and the role they play in determining medical necessity (type of claims, etc.),
b) the address was provided for the TPA vendor, and,
c) whether the TPA is affiliated with the Company or group.

Examination Conclusions: Based on the review of the third-party administrators and medical necessity claim determinations, the Company provided a sufficient response.

Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the utilization review medical necessity guidelines. Further, INS reviewed the data to:

a) verify that the M/S medical necessity guideline criteria were supplied,
b) verify that the MH/SUD medical necessity guideline criteria were supplied, and
c) review the medical necessity guidelines to determine if medical necessity criteria for MH/SUD are comparable to, or less strict than, those for medical/surgical care.

Examination Conclusions: The Company provided four entities that provide benefit determinations and the types of claims they oversee. The first entity conducts M/S and MH/SUD benefit determinations outside of the United States of America ("USA"). The second entity provides M/S benefit determination and utilization reviews inside the USA. The third entity that provides MH/SUD benefit determinations and utilization reviews inside the USA. The fourth entity is a PBM, which coordinates a network of pharmacies, mail order services, and claims administration for prescription drug claims. Based on the review of the medical necessity guidelines, the Company's medical necessity guidelines meet Massachusetts statutory and regulatory requirements

Sources for Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the sources used for determining medical necessity guidelines. Further, INS reviewed the data to:

a) verify the list of sources used by the Company in the development of the criteria for M/S was provided,
b) verify the list of sources used by the Company in the development of criteria for MH/SUD was provided,
c) verify that the sources for M/S medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies,
d) verify that the sources for MH/SUD medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies, and

e) determine if the Company modified the medical necessity criteria used by a third-party to be in line with Company objectives.

Examination Conclusions: Based on the review of the sources for medical necessity guidelines, the Company's medical necessity guidelines for M/S, MH, and SUD meet Massachusetts statutory and regulatory requirements.

Prior Authorization, Concurrent Review, and Retrospective Review

Note: Not all health insurance companies are required to perform concurrent and retrospective reviews in every instance. For example, a concurrent review typically focuses on treatments that are currently in progress. If a patient's treatment has been concluded or if the review is not pertinent to the ongoing care, a concurrent review may not be necessary. However, it should be noted that Massachusetts regulations do include requirements for concurrent review, primarily within the workers' compensation system and for health insurance carriers, to ensure the appropriateness and medical necessity of ongoing treatment, as outlined in Massachusetts General Laws, Chapter 176O, Section 12. Similarly, retrospective reviews may not be necessary in situations where the Company has made an effort to verify concurrent reviews by analyzing documentation and coding before claims are submitted, thereby ensuring accuracy.

Examination Procedures Performed: The examiners reviewed the approved, partially denied, and whole denials for prior authorization, concurrent reviews, and retrospective reviews, divided into M/S, MH, and SUD. Further, INS reviewed the data to:

a) develop averages and medians for M/S, MH, and SUD prior authorization, concurrent reviews, and retrospective reviews,
b) verify the Company supplied the prior authorization data for M/S, MH, and SUD,
c) verify the prior authorization approvals, denials, and partial denials are in line with statewide averages,
d) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
e) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
f) verify that the Company supplied the concurrent review data for M/S, MH, and SUD,
g) verify the concurrent review approvals, denials and partial denials are in line with statewide averages,
h) evaluate the concurrent review numbers provided by the Company and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
i) assess the concurrent review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
j) verify that the Company supplied the retrospective review data for M/S, MH, and SUD,
k) verify that the retrospective review approvals, denials, and partial denials are in line with statewide averages,
l) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
m) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S.

Examination Conclusions: The Company supplied only three prior authorization requests for the period of review. The Company had no MH or SUD claims, and there was no data related to concurrent review and retrospective reviews. Since the Company serves a niche market for expatriates, there may not be a need to conduct concurrent and retrospective reviews. Based on the review of the prior authorization, concurrent review, and retrospective review information supplied, the Company meets Massachusetts statutory and

regulatory requirements.

SUMMARY

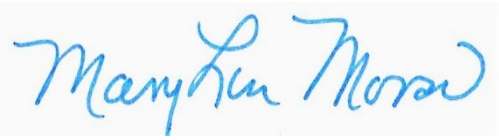
Based upon the procedures performed in this examination, INS has reviewed the Company's responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, complaint/grievance data, information verifying compliance with MHPAEA, and denials of payment and coverage, as set forth in the 2022 Handbook, the examination standards of the Division, and the Commonwealth of Massachusetts insurance laws, regulations, and bulletins.

ACKNOWLEDGEMENT

This acknowledgment is to certify that the undersigned is duly qualified and, in conjunction with INS, applied certain agreed-upon procedures to the Company's corporate records for the Division to perform a comprehensive market conduct examination of the Company.

The undersigned's participation in this comprehensive market conduct examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the NAIC and the Handbook. In addition, this participation consisted of involvement in the planning (development, supervision, and review of agreed-upon procedures), communication, and status reporting throughout the examination, administration, and preparation of the examination report.

The Division acknowledges the cooperation and assistance extended to all examiners by the officers and employees of the Company during the comprehensive market conduct examination.



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