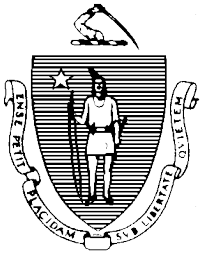

THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Comprehensive Market Conduct Examination of

Berkshire Life Insurance Company of America

Pittsfield, Massachusetts

For the Period January 1, 2021 through December 31, 2021

NAIC GROUP CODE: 0429

NAIC COMPANY CODE: 71714

EMPLOYER ID NUMBER: 75-1277524

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COMMONWEALTH OF MASSACHUSETTS
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MAURA HEALEY
GOVERNOR

KIM DRISCOLL
LIEUTENANT GOVERNOR

GARY D. ANDERSON
COMMISSIONER OF INSURANCE

October 27, 2023

The Honorable Gary D. Anderson
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
1000 Washington Street, Suite 810
Boston, Massachusetts 02118-6200

Dear Commissioner Anderson:

Pursuant to your instructions and in accordance with Massachusetts General Laws Chapter 175, § 4, a comprehensive examination has been made of the market conduct affairs of

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

which is based at their home offices located at:

700 South Street
Pittsfield, Massachusetts 01201

The following report thereon is respectfully submitted.

ACRONYMS

Berkshire Life Insurance Company of America (the "Company")
Commonwealth of Massachusetts Division of Insurance ("the Division")
Comprehensive market conduct examination ("examination")
Board of Directors ("Board")
Individual disability income ("IDI")
LifeCare Assurance Company ("LifeCare")
Long-term care ("LTC")
Market Conduct Annual Statement ("MCAS")
Massachusetts General Laws Chapter ("M.G.L. c.")
National Association of Insurance Commissioners ("NAIC")
Rudmose & Noller Advisors, LLC ("RNA")
Social Security Death Index ("SSDI")
Special Investigative Unit ("SIU")
Specially Designated Nationals and Blocked Persons ("SDN")
The Guardian Life Insurance Company of America ("Guardian")
2021 NAIC Market Regulation Handbook ("the Handbook")

SCOPE OF EXAMINATION

The Commonwealth of Massachusetts Division of Insurance (the "Division") conducted a comprehensive market conduct examination ("examination") of Berkshire Life Insurance Company of America (the "Company") for the period January 1, 2021 to December 31, 2021, with a focus on Massachusetts individual disability income ("IDI") and long-term care ("LTC") business. The Division called the examination pursuant to authority in Massachusetts General Laws Chapter ("M.G.L. c.") 175, § 4 and engaged representatives from the firm of Rudmose & Noller Advisors, LLC ("RNA") to complete the examination. The market conduct examination staff of the Division directed, managed, and controlled the examination process.

EXAMINATION APPROACH

The examination employed a tailored approach using the guidance and standards of the *2021 NAIC Market Regulation Handbook* ("the 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, including systems more efficiently addressed in the Division's financial Examination of the Company. To ensure that they adequately addressed the market conduct objective, where appropriate, RNA and the Division staff relied on procedures performed by the Division's financial examination staff as part of statutory financial examinations. The operational areas reviewed under this examination include company operations/management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting and rating, and claims. This examination report describes the procedures performed in these operational areas and the results of those procedures.

The Handbook provides guidance on optional processes and procedures for use during the examination and includes an approach designed to detect incidents of deficiency through transactional testing. The examination also has an operational and management assessment component. The review promotes an understanding of the critical controls used to operate the business and to meet essential business objectives, including measures designed to ensure compliance with applicable laws and regulations to market conduct activities.

This examination report constitutes a "Report by Test," as described in Chapter 15, Section A of the Handbook. An examination "finding" represents a violation of Massachusetts insurance laws, regulations, or bulletins. While an "observation" recognizes a departure from industry best practice. The recommendations accompanying the observation provide acceptable alternative practices. The Division recommends that Company management evaluate any "finding" or "observation" for applicability to other jurisdictions. When applicable, the Company should take corrective actions in all jurisdictions. 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 any such corrective actions taken.

EXECUTIVE SUMMARY

This summary provides a high-level overview of the examination results, while the remaining text summarizes all observations and conclusions noted during the examination., highlighting recommendations, or required actions. The examination did not include any recommendations or required actions concerning company operations, management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting, rating, or claims. Moreover, the examination indicated that the Company complies with all tested Company policies, procedures, and statutory requirements addressed in these areas. Further, the tested Company practices appear to meet industry best practices in these areas.

The Division recommends that Company managerial and supervisory personnel from each operational area review the examination report for results relating to their specific responsibilities. The Massachusetts laws, regulations, and bulletins cited in the report are on the Division's website at www.mass.gov/doi and available for review.

COMPANY BACKGROUND

The Company is a wholly-owned subsidiary of The Guardian Life Insurance Company of America ("Guardian"), founded in 1860. Guardian is one of the largest mutual life insurance companies in the United States, providing consumers with life, annuity, accident and health, and investment products. The Company was formed in 2001 from the merger of the former mutual insurer, Berkshire Life Insurance Company, into Guardian, whereby the mutual policyholders became policyholders of Guardian. Immediately following the merger, Guardian contributed assets and the continuing operations into the newly-formed insurer, primarily functioning as Guardian's disability income insurer. The Company also maintains a closed block of LTC policies, and thus no longer sells such coverage. The Company is licensed as a life and individual accident and health insurer and is authorized in all 50 states and the District of Columbia.

The Company and Guardian are rated A++ (Superior) by A.M. Best. Guardian is also rated AA+ (Very Strong) by Standard & Poor's, and Aa1 (High Quality) by Moody's. The following financial information of the Company is as of, or for the year ended December 31, 2021:

Admitted assets	$4,680.8 million
Statutory surplus	$220.9 million
Massachusetts business - direct written premium	$27.6 million

The Division determined the key objectives of this examination with emphasis on the following areas.

I. COMPANY OPERATIONS/MANAGEMENT

Corporate Governance:

Summary of Company Policies and Procedures:

- The Company's six-member Board of Directors ("Board") includes the President and five members of senior management of Guardian. The Board reviews and approves financial and operational plans, contractual and legal agreements, investment activities, and complaint and market conduct matters.
- Guardian's Board comprises ten independent directors, the President, and the Chief Executive Officer. The Guardian Board's standing committee charters delegate oversight of key risks through the Investment, Product and Development, Human Resources and Governance, and Audit and Risk Committees.
- The Company's and Guardian's operations are thoroughly integrated, including using the three-lines-of-defense model for enterprise risk management. The first includes internal and management controls within the operational areas, while the second entails the compliance, legal, finance, and enterprise risk management functions. Finally, the third line comprises the internal audit function, which conducts financial, operational, and compliance audits for the Company's and Guardian's business lines and operational areas.

Examination Procedures Performed: RNA interviewed Company personnel responsible for corporate governance, enterprise risk management, internal and external audit, compliance risk assessment, and market conduct matters. RNA also reviewed selected internal audit reports and Board meeting minutes.

Examination Conclusions: The Company has documented its corporate decisions in its Board minutes. Also, the Company has adopted policies and procedures to ensure that appropriate audits or reviews are conducted timely with documented results.

Third-Party Outsourcing:

Summary of Company Policies and Procedures:

- The Company contracts with a third-party, LifeCare Assurance Company ("LifeCare"), to administer LTC policyholder service transactions and claims.
- LifeCare management established performance metrics consistent with contractual service level objectives to monitor transaction processing as reported in monthly reports provided to the Company.
- Guardian's internal audit function conducts audits of LifeCare's operations and compliance with service level objectives.

Examination Procedures Performed: RNA interviewed management about using third parties to perform Company functions and the related monitoring procedures. RNA interviewed LifeCare's management about its business processes and reviewed related documentation concerning policyholder service and claims testing. RNA also reviewed Guardian's most recent internal audit report of LifeCare.

Examination Conclusions: Based upon review and testing, it appears that the Company's contracts with entities assuming a business function on its behalf comply with statutory and regulatory requirements.

Anti-fraud Efforts:

Summary of Company Policies and Procedures:

- The Company has a written anti-fraud plan that summarizes anti-fraud efforts and requires that management and employees take reasonable precautions to prevent and detect potential insurance fraud.
- Guardian's AML Officer leads the Special Investigative Unit ("SIU") and is responsible for detecting, investigating, and reporting fraud and cooperating with law enforcement and regulators investigating fraud.
- Within 90 days of hire, Guardian employees in the claims, underwriting, legal, and customer service departments must complete a fraud training program. Additionally, new SIU investigators receive training on detecting, investigating, and reporting different types of fraud.
- The Company has implemented Office of Foreign Asset Control compliance initiatives, including searches of the Specially Designated Nationals and Blocked Persons ("SDN") database for any policyholders, claimants, or vendors included in the SDN database.
- Annually, each employee must certify compliance with the Company's conflict of interest policy.

Examination Procedures Performed: RNA interviewed Company personnel responsible for anti-fraud initiatives, compliance procedures, and conflict of interest policies. In addition, RNA reviewed Company policies and procedures to address anti-fraud initiatives as part of marketing and sales, underwriting, policyholder service, and claims testing.

Examination Conclusions: The Company has adopted reasonable procedures related to anti-fraud initiatives, compliance procedures, and conflict of interest policies. Based upon testing, it appears that the Company has reasonably implemented anti-fraud initiatives to detect, prevent, and investigate fraudulent insurance acts.

Record Retention:

Summary of Company Policies and Procedures:

- The Company has adopted record retention requirements for various documents and records.
- The requirements include record management maintenance, disposal guidelines, and document-specific retention timelines.

Examination Procedures Performed: RNA obtained a summary of the Company's record retention policies and procedures and evaluated them for reasonableness.

Examination Conclusions: The Company's record retention policies appear reasonable and sufficient.

Privacy Compliance:

Summary of Company Policies and Procedures:

- The Company provides the required privacy notice annually to all policyholders.
- The privacy notice states that the Company shares personal information with entities administering operations for the Company.
- The Company does not share information with other non-affiliates except for entities where Guardian has a joint marketing agreement. While the Company is not required to offer an opt-out consumers can opt-out of such sharing for marketing purposes on the Guardian website.
- The Company discloses information following statutory provisions to regulators, law enforcement agencies, and anti-fraud organizations.
- The Company has implemented information technology security policies and practices to safeguard non-public personal and health information.
- The Company restricts access to electronic and operational areas containing non-public personal financial and health information to authorized individuals and strictly monitors access procedures.

Examination Procedures Performed: RNA interviewed Company personnel responsible for privacy compliance and reviewed supporting documentation. Further, RNA

a) reviewed marketing and sales, underwriting, policyholder service, and claims documentation for evidence that the Company improperly collected, used, or disclosed non-public personal financial information, and
b) sought evidence that the Company improperly disclosed non-public personal health information in conjunction with such testing.

Examination Conclusions: Based on review and testing, the Company's privacy practices appear to meet Massachusetts and Federal statutory and regulatory requirements.

Annual Market Conduct Reporting:

Summary of Company Policies and Procedures:

- The Company's policy administration and claims systems compile and retain IDI and life underwriting, policyholder service, and claim data for inclusion in the annual financial reporting to the Division, and for inclusion in the National Association of Insurance Commissioners ("NAIC") Market Conduct Annual Statement ("MCAS").
- LifeCare's policy administration and claims systems compile and retain LTC policyholder service and claim data for inclusion in the Company's annual financial reporting to the Division and for inclusion in the MCAS.

Examination Procedures Performed: RNA interviewed personnel responsible for IDI underwriting, IDI and LTC policyholder service, and IDI and LTC claims processing. In addition, RNA reviewed the 2021 annual financial reporting submitted to the Division, the examination data, and the Company's 2021 Massachusetts MCAS filing.

Examination Conclusions: Based upon review and testing, the 2021 Massachusetts MCAS filing appears reasonably complete and accurate.

II. COMPLAINT HANDLING

Summary of Company Policies and Procedures:

- The Company defines a complaint as a written expression of dissatisfaction related to business practices, policies, products, or services. Complaints are tracked within a database and addressed in accordance with written procedures.
- Resolution Liaisons, who coordinate with management in operational areas work to ensure complaints are timely addressed and documented. After an evaluation, the Liaisons code the complaints as substantiated or not substantiated and provide a response to the complainant and/or regulator.
- The Company monitors social media for any expressions of grievance. In such cases, they contact the consumer to obtain a written summary off-line, which then is processed as a complaint.
- Complaint activity and trends are reported to the Company's Board quarterly.

Examination Procedures Performed: RNA interviewed Company staff, including management personnel responsible for complaint handling. Two complaints were reported in 2020 and 2021. The examiners reviewed evidence of related processes and controls and tested both reported complaints.

Examination Conclusions: Based on review and testing, the Company's complaint register and the complaint procedures meet Massachusetts statutory and regulatory requirements, and the complaints appear to be properly and timely handled.

III. MARKETING AND SALES

IDI Sales and Advertising Materials:

Summary of Company Policies and Procedures:

- The Company's compliance function uses an electronic workflow system to track and review IDI sales, advertising, and agent training materials. For career agent-developed materials, the Company's agency management reviews and approves them before submitting them to the compliance function.
- The electronic workflow system identifies each piece with a number and an expiration date. Shortly before the expiration date, notice is given to relevant parties of the soon-to-expire materials so that updates can be processed as needed.
- The Company's website does not include specific IDI products offered but discusses general consumer information about IDI insurance.

Examination Procedures Performed: RNA interviewed Company personnel responsible for reviewing, approving, and maintaining sales, advertising, and training materials and obtained supporting documentation. Further, RNA

a) tested 20 selected advertising and training materials in use in Massachusetts for approval, appropriateness, reasonableness, and
b) reviewed any sales and marketing materials and agent communications noted as part of new business testing for evidence of using unapproved sales and marketing materials.

Examination Conclusions: Based on RNA's review and testing, the Company's sales, advertising, and training materials and the related procedures appear to be properly approved, appropriate, and reasonable.

IDI Consumer Needs Assessment and Replacement Procedures:

Summary of Company Policies and Procedures:

- Agents discuss IDI coverage needs with the consumer and obtain financial and medical information to complete the application following the Company's *Field Underwriting Guide*. The Company's electronic software ensures that Massachusetts-approved applications, disclosure notices, replacement forms, policy summaries, and policy forms are used with the proposed sale.
- The applicant and the agent electronically or manually sign the application.
- If the proposed sale replaces coverage, a Massachusetts replacement notice is provided to the applicant. Approximately 2% of Massachusetts sales in 2021 were considered replacements.
- The submitted application package is assigned to a new business case manager for review, with any questions or deficiencies identified and returned to the agent for additional information. Once the new business area approves, the application package is forwarded to underwriting for review.

Examination Procedures Performed: RNA interviewed individuals responsible for IDI new business processing. Further, RNA tested 65 submitted Massachusetts IDI applications to assess whether the applications, disclosures, replacement forms, summaries and policy forms were properly used, completed, signed, and evaluated. Six replacement applications for issued policies were included in the testing sample.

Examination Conclusions: Based on review and testing, the Massachusetts IDI insurance applications and related disclosures, replacement forms, summaries, and policy forms were properly used, completed, signed, and evaluated in accordance with contractual and Massachusetts statutory and regulatory requirements.

IV. PRODUCER LICENSING

Summary of Company Policies and Procedures:

- The Company's sales are through licensed producers appointed as agents.
- Guardian conducts criminal, employment, and financial background checks for career agent applicants.
- The agency contracts specify the terms of the appointment, which is perpetual until terminated, along with provisions related to expense allowances, commission structure and payment, books and records, privacy, security, advertising compliance requirements, indemnification, and termination.
- The Company's agency or agent appointment terminations are provided through a written notice at least 30 days prior to the termination effective date. Appointment terminations that are "for cause" are rare and handled according to the contractual and statutory requirements.

Examination Procedures Performed: RNA interviewed individuals responsible for producer contracting and processing agent appointments and terminations. Further, RNA

a) tested 65 submitted Massachusetts IDI insurance applications to determine whether the producers were licensed and appointed as agents in Massachusetts, and
b) tested 15 agent or agency appointment terminations to ensure that the terminations, including required notices, were timely and met contractual and statutory requirements.

Examination Conclusions: Based on testing, the Company's producer licensing, agent appointment, and agent termination practices meet contractual and Massachusetts statutory requirements.

V. POLICYHOLDER SERVICE

Insured-Requested Cancellation and Contract Change Requests:

Summary of Company Policies and Procedures:

- The Company's IDI call center staff and LifeCare's LTC call center staff answer policyholder questions, process address and billing changes, and process electronic premium payments with the calls documented in a workflow system. Management monitors incoming phone calls, and tracks call center activity, including average call answer rate and monthly average abandon rate. Call center metrics are measured and reported to senior management.
- IDI and LTC cancellation and contract change requests require a completed form, including the insured's signature or a voice-authorized or electronic signature. All received forms and correspondence are scanned, imaged, and processed in policy administration systems. The requests are processed when the signed form is received. Any unearned premium is returned to the insured and calculated from the date of the request. Reductions in benefit payments, or increases in the contractual elimination period, are initially processed within five days.
- The underwriting department reviews and approves requests for increases in IDI benefit coverage.

Examination Procedures Performed: RNA interviewed individuals responsible for IDI and LTC policyholder service transaction processing. Further, RNA tested 17 IDI insured-requested cancellations and contract changes and two LTC contract changes from the examination period to determine whether the cancellations and contract changes were processed accurately and timely.

Examination Conclusions: Based on testing results, procedures for IDI and LTC insured-requested cancellations and contract changes meet contractual and Massachusetts statutory and regulatory requirements.

Premium Billing, Lapse, and Reinstatement Transactions:

Summary of Company Policies and Procedures:

- The policy administration system automatically generates IDI premium billings approximately 20 days before the payment due date. Insureds may select from quarterly, semi-annual, or annual paper billing or elect monthly, semi-annual, or annual electronic funds transfer. If payment is not received by the due date, a reminder overdue payment notice is sent approximately 15 days after the due date. A pending lapse notice is sent if the premium has not been paid after 31 days from the due date. A lapse notice is sent after 70 days noting that the policy has lapsed. The consumer may elect to reinstate the policy within 180 days, subject to the approval of the underwriting department, and after completing the reinstatement application.
- LifeCare's policy administration system automatically generates LTC premium billings approximately 45 days in advance of the premium due date. Insureds may select from quarterly, semi-annual, or annual billing or elect monthly electronic funds transfer. If LifeCare does not receive payment by the due date, a reminder overdue payment notice is sent approximately seven days after the due date. A pending lapse notice is sent if the premium has not been received 31 days after the due date. After an additional 35-day grace period expires, the policy will lapse on the 67th day. The consumer may elect to reinstate the policy within one year, subject to the approval of the underwriting department and after completing a reinstatement application.

Examination Procedures Performed: RNA interviewed individuals responsible for premium billing, lapses, and reinstatements and examined evidence of related processes and controls. Further, RNA tested eight IDI lapses, two of which were reinstated, and the sole LTC lapse during the examination period to determine whether the transactions were processed accurately and timely.

Examination Conclusions: Based on testing, the handling of lapses and reinstatements meet contractual and Massachusetts statutory and regulatory requirements.

Returned Mail, Unclaimed Checks, and Escheatment Practices:

Summary of Company Policies and Procedures:

- Staff scan, image, and process all returned mail in a workflow system. If necessary, staff research various databases to find a better address for the policyholder and may contact agents for information that may help locate the insured.
- Guardian conducts a quarterly search of all policy administration systems using the Social Security Death Index ("SSDI") to identify any unknown policyholder deaths. Guardian processes the appropriate action or transaction for deceased policyholders confirmed through the SSDI. Also, Guardian performs a monthly search for IDI policies that are on long-term claim-paying status, with any death information shared with all Guardian's operational areas for other policy implications.
- For escheatment of unclaimed benefits, the Guardian treasury function tracks uncashed premium refund and claim checks. The business area that issued the check will research to confirm the current address and advise the treasury to send a letter to the consumer's last known address, noting that a check remains uncashed, with instructions about receiving the payment.
- If the amounts remain unclaimed three months before the three-year escheatment period, a final written attempt to reach the consumer is made. If the funds remain unclaimed, the Company will escheat the funds in accordance with the applicable statute through the annual filing with the Massachusetts State Treasurer.

Examination Procedures Performed: RNA interviewed individuals responsible for returned mail, unclaimed checks, and escheatment and reviewed supporting information, including the 2020 and 2021 escheatment filings with the Massachusetts State Treasurer.

Examination Conclusions: Based on review, the Company's handling of returned mail, unclaimed checks, and escheatment meet Massachusetts statutory and regulatory requirements.

VI. UNDERWRITING AND RATING

Summary of Company Policies and Procedures:

- The IDI application package from the new business area is forwarded to the underwriting department for review using an automated workflow system, which assigns it to an underwriter based on case complexity and issue limits, and tracks it for further review.
- Medical Insurance Bureau reports provide the applicant's medical history and a history of IDI applications with other insurers in the last two years. The underwriters verify any IDI coverage in-force and ensure the applicant would not be over-insured.
- The applicant's medical and prescription drug history from a third-party is obtained and includes names of attending physicians, medical diagnostic codes, and procedural codes. Attending physician statements or lab tests are ordered when warranted by the *Field Underwriting Guide*. The Company does not obtain or use credit data in its underwriting process.
- The *Field Underwriting Guide* has non-medical guidelines for occupation and income. Underwriting staff may obtain financial information, such as tax returns, to confirm current income.
- Underwriters have authority limits, and applied for amounts exceeding those limits are approved by an underwriter with sufficient underwriting authority. For new underwriters, supervisory reviews are conducted on all work until the underwriters are released to underwrite cases up to their authority limits. For complex applications, an underwriter will generally discuss the application with a mentor, supervisor, medical director, or financial expert.
- As filed and approved with the Division, premium rates are automated and applied based on the applicant's occupational class, age, gender, job duties, years of experience, health, and habits. Premium surcharges may be used to increase premium rates based on underwriting information about the applicant's risk, and standard discounts are often offered in accordance with approved rate filings.
- If the applicant is offered a different rate than quoted or is declined coverage, the applicant will receive an Adverse Underwriting Decision Notice. The Notice provides the reason for the underwriting decision and informs the applicant how to obtain a copy of any medical information the Company used in making the decision. The applicant may provide additional or corrected information for reconsideration of coverage.

Examination Procedures Performed: RNA interviewed Company personnel responsible for the IDI underwriting and rating processes. Further, RNA tested 65 submitted Massachusetts IDI insurance applications to determine

a) whether the *Field Underwriting Guide* supported the underwriting conclusions,
b) whether Adverse Underwriting Decision Notices were issued when the premium rate offered was different than the quoted rate;when exclusions were offered or when the application was declined,
c) for those applications not declined, whether the premium rating and discounts were properly applied in accordance with filed and approved premium rates, and
d) whether the Company processed the application following statutory and regulatory requirements and the Company's policies and procedures.

Examination Conclusions: Based on review and testing, RNA determined

a) the *Field Underwriting Guide* supported the underwriting conclusions,
b) the Company issued adverse Underwriting Decision Notices when the premium rate offered was different than the quoted rate, when they offered exclusions, or when declining the application,
c) the Company applied premium rating, and discounts properly in accordance with filed and approved premium rates, and
d) the Company processed applications following statutory and regulatory requirements and its policies and procedures.

VI. CLAIMS

Summary of Company Policies and Procedures:

For IDI claims:

- The Company's service desk receives the first-notice-of-loss, sends claim forms within one day, and contacts the claimant within five days to explain the claims process. Once the Company receives a completed claim package, the claim is assigned to a claims examiner.
- An internally-developed electronic claim handling and workflow system is used for history notes, diary reminders, and document management.
- The claims examiner processes the waiver of premium benefit, which typically involves premium refunds due to the insured. The Company does not require the policyholder to pay premiums during the claims benefit period.
- The SIU function assists with questions about potential fraud as needed.
- The claims examiner reviews the claim package, inquires about any questions or missing information, and requests any medical information, attending physician statements, and financial information. The Company requires representatives to return phone calls from claimants within 24 hours and that responses to written claimant correspondence are issued within ten business days.
- The Company sends status letters to claimants every 20 days until it reaches an eligibility decision. A claims manager reviews all filed claims and proposed payments.
- Denied claims require two levels of supervisory review. The denial letter includes specific reasons for the denial and the information relied upon in making the denial decision, applicable policy provisions, and what additional information the Company would consider if submitted by the claimant. The letter also provides the Division's contact information. Claimants have 180 days to appeal and request reconsideration. If the claimant submits new information, the current claim team will reconsider the initial denial decision. However, if the claimant does not submit new information, a new claims team will evaluate the request.
- IDI claims may require periodic confirmation of the insured's continued disability and ongoing benefit eligibility. The frequency of reporting may be tailored to each claim.

For LTC claims, which are processed by LifeCare:

- LifeCare processes LTC claims within its workflow system. Two claims adjusters and one supervisor handle the claims. When a claim is reported via phone, the in-take team sends the claim forms to the claimant within two business days and assigns one of the two claim adjusters.
- Attending physician statements and medical records are ordered by the claim adjuster, and a staff nurse assists adjusters in assessing the claimant's medical condition. LifeCare uses medical consultants as needed.
- LifeCare sends status letters to claimants every 30 days until the LifeCare adjuster makes an eligibility decision. When the adjuster completes the assessment, the adjuster sends the claimant a written communication approving or denying benefit eligibility. For those that are approved, LifeCare processes the waiver of premium benefits.
- The claim denial letters note specific reasons for the denial. A supervisor reviews and must concur with each denial decision. Appeals of claim denials must be in written form and are evaluated by the original adjuster and supervisor. If the appellant submits no new information, an independent review is performed, and a final decision is rendered within 30 days.
- The insured must recertify benefit eligibility at least annually and in some cases, more frequently. LifeCare checks in-force policies against the SSDI every two weeks to identify deceased insureds.
- Life Care uses performance metrics to monitor processing times and reports this information monthly to the Company. LifeCare's goal is to process requests for benefit eligibility within 30 days after receipt of the requested information. For claim payment requests the goal is to process all claim payment requests within ten days.

Examination Procedures Performed: RNA interviewed Company personnel responsible for IDI and LTC claims handling. RNA selected 60 IDI claims, including 22 newly-reported or paid claims, eight denied claims, two closed claims, eight claims pending a benefit determination, and 20 claims in active payment status. RNA selected eight LTC claims, including two newly-reported or paid claims, one denied claim, three claims pending a benefit determination, and two claims in active payment status. In addition, RNA verified that the IDI and LTC claims were properly investigated, adjudicated, and paid or denied following contract provisions and statutory requirements.

Examination Conclusions: Based upon review and testing, IDI and LTC claim handling practices appear to meet contractual and Massachusetts statutory and regulatory requirements.

SUMMARY

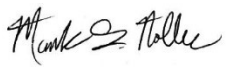
Based upon the procedures performed in this examination, RNA has reviewed and tested company operations/management, complaint handling, marketing and sales, producer licensing, policyholder service, underwriting and rating, and claims as set forth in the Handbook, the examination standards of the Division, 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 RNA, applied certain agreed-upon procedures to the Company's corporate records for the Division to examine the Company.

The undersigned's participation in this 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 examination.



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Mark G. Noller, CIE
Rudmose & Noller Advisors, LLC
Commonwealth of Massachusetts Division of Insurance
Boston, Massachusetts

Mary Lou Moran

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Mary Lou Moran, Esq.
Direct of Market Conduct
Commonwealth of Massachusetts Division of Insurance
Boston, Massachusetts