REPORT ON EXAMINATION

of the

CARITEN HEALTH PLAN INC.
1420 CENTERPOINT BLVD.
KNOXVILLE, TENNESSEE

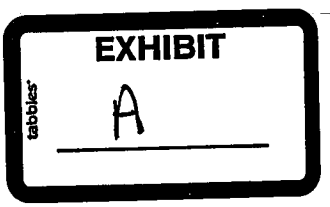
as of

DECEMBER 31, 2005

DEPARTMENT OF COMMERCE AND INSURANCE

STATE OF TENNESSEE

NASHVILLE, TENNESSEE



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Nashville, Tennessee
June 11, 2007

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

Dear Commissioner:

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

CARITEN HEALTH PLAN INC.
1420 CENTERPOINT BOULEVARD
KNOXVILLE, TENNESSEE

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

INTRODUCTION

This examination was called by the Commissioner of Commerce and Insurance, State of Tennessee ("Commissioner") and commenced on April 18, 2006. The examination was conducted under the association plan of the NAIC by duly authorized representatives of the Department of Commerce and Insurance, State of Tennesseee ("Department").

SCOPE OF EXAMINATION

This examination report covers the period from December 31, 2001, the date of the previous examination, to the close of business on December 31, 2005, and includes any material transactions and/or events occurring subsequent to the examination date and noted during the course of the examination.

The examination of the financial condition was conducted in accordance with guidelines and procedures contained in the NAIC Examiners Handbook. During the course of examination, assets were verified and valued and liabilities were determined and estimated as of December 31, 2005. The financial condition of the HMO and its amount

of solvency were thereby established. Test checks were made of income and disbursement items for selected periods, and a general review was made of the HMO's operations, practices, and compliance with applicable statutes and regulations. All asset and liability items contained in the financial statement of this report were examined and verified with relative emphasis according to their amount and potential impact on capital and surplus.

In addition, the following topics were reviewed:

HMO History
Charter and Bylaws
Management and Control
Corporate Records
Fidelity Bonds and Other Insurance
Territory
Plan of Operation (includes inforce/premium by state)
Market Conduct Activities (includes privacy statement)
Retirement Plan and Other Employee Benefits
Loss Experience
Accounts and Records
Statutory Deposits
Agreements with Parent, Subsidiaries and Affiliates
Pecuniary Interest - Tenn. Code Ann. § 56-3-103
Dividends or Distributions
Litigation
Subsequent Events
Financial Statement

The previous examination was conducted as of December 31, 2001, by authorized representatives of the Department.

Three (3) recommendations were made to the HMO from the last exam.

1. The HMO should submit its Service Agreement and its Tax Allocation Agreement to the Department of Commerce and Insurance for the stamp approval of the Commissioner of Insurance pursuant to the Tenn. Code Ann. § 56-11-206(a)(2)(D). These agreements were approved by the Department in September 2003, as further described in the "Agreements with Parent, Subsidiaries and Affiliates Section" below.
2. A review of the HMO's claims payment system revealed that the HMO is not in compliance with Tenn. Code Ann. § 56-7-109gjm(b) which states that ninety five percent (95%) of clean claims submitted on paper must be paid within thirty (30) days of receipt. Based on the results of tests completed during this examination, the HMO appears to be in compliance with this requirement as of December 31,

2005. The results of this testing are presented in the "Prompt Payment – Tenn. Code Ann. § 567-7-109 Section" below.

3. The HMO should develop and implement controls and procedures to adhere to the instructions for preparation of the annual statement. By adding additional training for employees in 2003, the Company seemed to have made efforts to correct and address this issue.

HMO HISTORY

The HMO was incorporated on September 13, 1994, as a for-profit corporation under the provisions of the Tennessee General Corporation Act, with the name "PHP Health Plans Inc." The HMO recorded the charter with the Secretary of State, State of Tennessee. The HMO's original principal place of business was 280 Fort Sanders West Boulevard, Suite 205. Knoxville, Tennessee. The HMO was certified on December 31 1995, and commenced business on January 1, 1996.

On November 20, 1996, the HMO amended its charter to change the name of the HMO to "Cariten Health Plan Inc." The Department approved the amendment on November 27, 1996. The amendment was recorded with the Secretary of State, State of Tennesseee on December 4, 1996. The amendment was recorded with the Register of Deeds of Knox County on December 9. 1996. A new Certificate of Authority was issued to the HMO on January 7, 1997.

The charter of the HMO authorized the issuance of one hundred thousand (100,000) shares of common stock with a par value of one dollar ($1.00) per share. Effective September 13, 1994, the HMO became a wholly-owned subsidiary of PHP Companies Inc., a Tennessee for-profit corporation.

At December 31, 2005, the HMO had one hundred thousand dollars ($100,000) of common stock, thirty-one million two hundred fourteen thousand five hundred twenty-eight dollars ($31,214,528) of contributed capital, and negative three million six hundred sixteen thousand seven hundred forty-four dollars ($3,616,744) in unassigned funds

A summary of the HMO's paid in funding provided by the parent corporation since the prior examination is as follows:

Statement Date	Paid in surplus	Paid in capital
December 31, 2002	$0	$0
December 31, 2003	$221,484	$0
December 31, 2004	$0	$0
December 31, 2005	$0	$0
Total	$221,484	$0

GROWTH OF HMO

The following exhibit depicts certain aspects of the growth and financial history of the HMO since the previous examination, according to annual statements filed with the department:

Date	Net Premium	Net Investment Income	Medical & Hospital Expenses	Claims & Admin. Expenses	Net Income/ (Loss)	Net Assets	Net Worth
12/31/01	$74,993,458	$2,196,966	$60,971,644	$8,775,383	$7,760,330	$46,455,530	$17,539,500
12/31/02	$102,769,246	$2,225,429	$91,834,101	$8,133,572	$5,103,943	$49,378,437	$17,083,624
12/31/03	$131,915,523	$1,900,419	$122,898,442	$7,263,672	$2,125,974	$58,057,645	$23,607,399
12/31/04	$170,880,194	$2,258,745	$160,400,858	$10,307,735	$1,343,904	$64,810,610	$26,978,082
12/31/05	$226,034,936	$3,173,168	$201,232,377	$13,515,640	$7,930,081	$76,637,146	$27,697,784

CHARTER AND BYLAWS

Charter:

The original undated charter of PHP Health Plans, Inc. was filed and recorded with the Secretary of State, State of Tennessee on September 13, 1994, after having been approved by the Department on September 9, 1994. The objectives and purposes for which the said HMO is organized, and the natures of its powers and of the business to be carried on by it, are as follows:

(1) The name of the corporation is PHP Health Plans, Inc.

(2) The corporation authorized issuance of one hundred thousand (100,000) shares of common stock, with each share to have a par value of one dollar ($1.00).

(3) The purposes for which this corporation is organized are as follows: To conduct business as a health maintenance organization and to carry on all activities ancillary thereto; and to engage in any lawful act or activity for which corporations for profit may be organized under the laws of the State of Tennesseee; and the corporation shall have all powers necessary to conduct such businesses and engage in such activities, including, but not limited to, the powers enumerated in the Tennessee

Business Corporation Act or any amendment thereto.

(4) The corporation is for profit.

(5) The street address of the principal office of the corporation is 280 Fort Sanders West Boulevard, Suite 205, Knoxville, TN 37922

Charter amendments were discussed under the caption "HMO History". The charter has not been amended since the previous exam date of December 31, 2001.

Bylaws:

The Bylaws of the HMO in effect at December 31, 2005, were adopted September 30, 1994. The HMO has not amended or adopted new bylaws to reflect its present name. This issue was referred to management. See the "Comments and Recommendations Section" below.

Bylaws may be amended or repealed either by the shareholders or the Board of Directors as provided by statute. Any change in the bylaws made by the Board of Directors, however, may be amended or repealed by the shareholders.

An annual meeting of shareholders shall be held during December each year or at a time which is within the period beginning sixty (60) days prior to the close of any fiscal year and ending six (6) months following the close of any fiscal year. Special meetings of the shareholders may be called by the Board of Directors, the president or the secretary. Shareholder meetings shall be held at the principal office of the corporation or at any other place, within or without the State of Tennessee, as designated.

The number of members on the Board of Directors shall be set at any meeting of the shareholders. Directors need not be shareholders or residents of this state. Terms are not to exceed three (3) years. Each director shall hold office until the expiration of the term for which the director is elected, and thereafter until a successor has been elected and qualified.

The officers of the HMO shall be elected or appointed by the Board of Directors at the annual meeting. Offices include president and secretary and such other officers as may be appointed. The same individual may simultaneously hold more than one office except for the office of president and secretary.

MANAGEMENT AND CONTROL

Management:

The Bylaws provide all corporate powers shall be exercised by or under the authority of and the business and affairs of the HMO managed under the direction of the Board of Directors. Board members are elected by the shareholders. As of December 31, 2005, the Board of Directors of the HMO was composed of the following:

Kenneth T. Creed
Thomas R. Bell
Sandra L. Mathy
Randolph M. Lowry MD
Michael M. Dudley
Michael E. Mitchell MD
Marvin H. Eichorn
Kenneth F. Luckmann MD
Francis H. Olmstead Jr.
Dean M. Turner MD
David A. Nowiski
Daniel J. David MD
Cletus J. McMahon Jr. MD
Anthony L Spezia

As of December 31, 2005, the following persons held office in the HMO:

Lance K. Hunsinger	President
Jeff Collake	Secretary
Jeff Collake	Chief Financial Officer

The administrative and executive functions of the HMO are performed by staff provided by PHP Companies, Inc. under execution of a management agreement. The relationship with the mentioned firm is discussed under the heading "Agreements with Parent, Subsidiaries and Affiliates". Certain services were purchased in past years from outside contractors if needed and were not available from in house personnel. Such services included independent audit services.

Control:

The HMO is one hundred percent (100%) owned by PHP Companies, Inc. (PHP), a holding company domiciled in the State of Tennessee. Covenant Health (Covenant), a tax-exempt entity under Section 501(c)(3) of the Internal Revenue Code, is the majority

stockholder of PHP, owning ninety-eight percent (98%) of the stock with the remaining two percent (2%) owned by Mountain States Health Alliance.

A holding company organizational chart is included at the last page of this examination report.

CORPORATE RECORDS

Minutes of meetings of the shareholders and Board of Directors of the HMO were reviewed for the period under examination. There was no indication that adequate approval and support was given for financial transactions and events pursuant to Tenn. Code Ann. § 56-3-408(b)(1). This issue was referred to management. See the "Comments and Recommendations Section" below.

FIDELITY BOND AND OTHER INSURANCE

The following is a schedule of the enumerated coverages at December 31, 2005:

Type of Coverage	Coverage Limits
A. Employee Dishonesty Coverage	$1,000,000

Retention on the policy is ten thousand dollars ($10,000). Coverage is underwritten by Travelers Casualty and Surety Company of America which is licensed in Tennessee as a "Foreign Property and Casualty Insurer". This policy is issued to PHP Companies, Inc. The HMO has no employees.

The HMO's fidelity bond coverage exceeds the suggested minimum as exhibited in the NAIC Financial Condition Examiners Handbook.

B. Directors, Officers and Private HMO Liability Coverage	$10,000,000

Retention on the policy is two hundred fifty thousand dollars ($250,000). Coverage is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. which is licensed in Tennessee as a Foreign Property and Casualty Insurer. This policy is issued to PHP Companies, Inc. and includes subsidiary coverage.

C. Managed Care Organization Errors and Omissions Liability Coverage	$5,000.000

Retention on the policy is five hundred thousand dollars ($500,000). Coverage is

underwritten by Darwin Select Insurance Company, which is not licensed in Tennessee but qualifies as a surplus lines insurer pursuant to Tenn. Code Ann. § 56-14-108. This policy is issued to PHP Companies, Inc. and includes the HMO as an insured.

TERRITORY

As of December 31, 2005, the HMO was licensed to transact business only in the State of Tennessee. The Certificate of Authority for the State of Tennesseee was reviewed.

The HMO's service area in Tennessee consists of the following counties:

Anderson	Greene	Knox	Rhea
Blount	Hamblen	Loudon	Roane
Bradley	Hamilton	McMinn	Sevier
Campbell	Hancock	Meigs	Sullivan
Carter	Hawkins	Monroe	Unicoi
Claiborne	Jefferson	Morgan	Union
Grainger	Johnson	Polk	Washington

As of December 31, 2005, the HMO had written direct premium as follows in Tennessee:

State	Accident and Health	Medicare Title XVIII
Tennessee	$37,806,819	$188,228,117
Total	$37,806,819	$188,228,117

PLAN OF OPERATION

The company was formed to conduct business as a health maintenance organization and to carry on all activities ancillary thereto. Tenn. Code Ann. 56-32-202(7) define an HMO as "any person that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis."

The HMO contracts with healthcare professionals, healthcare facilities and group providers are as follows:

- Agreements with healthcare professionals reimburse providers through a fee-for-

service basis for covered services at the lesser of the provider's billed charges or the most current appropriate point of service and preferred provider benefit program fee schedule.

- Healthcare facilities agreements compensate providers for inpatient services, outpatient services and emergency services, to be reimbursed at the lesser of billed charges or the scheduled rates included in the agreement.
- Group Provider agreements reimburse providers through a fee-for-service basis for covered services at the lesser of the provider's billed charges or the most current appropriate point of service and preferred provider benefit program fee schedule.
- Pharmacy benefits are serviced through a single prescription benefits manager who administers the pharmacy claims processing.

These contracts were reviewed for compliance with Tenn. Code Ann. § 56-32-205(c) which states that "HMO members must be relieved from any liability for services rendered by such providers except for reasonable co-payment and uncovered expenses", and they comply.

The HMO's target market consists of both small employer groups consisting of three (3) to twenty-five (25) employees and large employer groups consisting of twenty-six or more employees. The HMO utilizes a network of brokers to market its fully funded products and a licensed sales staff for onsite or offsite Medicare seminars.

In 1998, the HMO entered into a risk-based contract with the Centers for Medicare and Medicaid Services (CMS) to provide or arrange for the provision of health care services to senior citizens who have both Medicare Part A and Medicare Part B entitlement. This contract, which is renewable annually, provides basic and supplemental benefits to enrollees as required under federal regulation. Members can also purchase additional benefits by paying premiums directly to the HMO.

Pharmacy costs derive through a services agreement with ProCare Rx. ProCare Rx provides consultation on prescription benefit programs, claims processing capabilities, offers pharmacy provider retail and mail service networks, and maintains a drug formulary. Before December 29, 2004, pharmacy benefits were contracted through Express Scripts.

The Service Agreement with ProCare Rx has not been submitted to the Department as required pursuant to Tenn. Code Ann. § 56-32-203(b)(4) and (c)(1).

Enrollment History:

Year	Total members	Group	Title XVIII Medicare
2001	22,531	13,174	9,357
2002	27,938	15,570	12,368
2003	32,727	16,210	16,517
2004	34,967	13,278	21,689
2005	41,547	14,553	26,994

MARKET CONDUCT ACTIVITIES

A market conduct review was made of the HMO as of December 31, 2005, in conjunction with this examination. The following items were addressed:

Filing and Approval of Policy Forms:

The HMO is aware of the filing responsibility for various forms, agreements, etc., as well as "hold harmless" requirements for provider contracts pursuant to Tenn. Code Ann. § 56-32-205(c). During the period of this examination, the last approved rate filing was filed with the Department on October 14, 2005.

Inquiries were made to the Department regarding any issues with current filings. The Department advised of needed updates to the HMO's Physicians' manual and provider contracts. This issue was referred to management. See the "Comments and Recommendations" section below.

Policy forms and other material filed with the Department made by the HMO during 2005 and 2006 were reviewed and no deficiencies were noted.

Underwriting:

The HMO has posted its Group Underwriting forms on its website (www.cariten.com). The HMO maintains basic underwriting eligibility requirements for commercial groups and medicare advantage customers.

Advertising:

All advertising is based on individual products. The product advertising consists of direct mail, television spots, newspaper ads, member newsletters, and employer brochures, as well as the HMO's website (www.cariten.com).

Claims Review:

Commercial products are subject to Tenn. Code Ann. § 56-32-210. A sample of commercial claim files reviewed during the examination indicated that claims were being paid in accordance with policy provisions and settlements were made promptly upon receipt of proper evidence of the HMO's liability.

Prompt Payment - Tenn. Code Ann. § 56-7-109

Following the prior financial examination of December 31, 2001, a prompt pay examination was performed by the Department. This exam covered the period of January 1, 2004 to December 31, 2004. Testing was performed during the review, in accordance with Tenn. Code Ann. § 56-7-109(b), and provided a credible basis for the findings and recommendations. Such examination showed the HMO's changes to its claims handling system has allowed the reporting of clean claim dates.

At the Department's request, the HMO stratified the commercial and Medicare claim population for the year, 2005, into clean claims by month in order to measure timeliness of payment. Tenn. Code Ann. § 56-7-109 requires payment within twenty-one (21) days for electronic clean claims and thirty (30) days for paper clean claims. The results of this claim stratification are as follows:

Electronic medical claims = EDI	21 day requirement
Paper claims which are scanned for entry = OCR	30 day requirement

	Jan	Feb	Mar	Apr
Claims Received	13,296	13,722	15,501	14,214
EDI	10,022	10,253	11,945	11,042
OCR	3,274	3,469	3,556	3,172
$ of Claims paid	$1,411,178	$2,732,271	$3,114,414	$2,317,299
Average Turn Around Time (# of days to check date)				
% of claims within 7 days	74.52%	68.90%	67.88%	76.74%
% of claims within 14 days	91.20%	89.73%	91.08%	96.96%
% of claims within 21 days	98.38%	98.02%	96.05%	98.55%
% of claims within 30 days	98.77%	99.02%	97.02%	98.85%
% of claims within 60 days	99.39%	99.32%	98.97%	99.52%

	May	June	Jul	Aug
Claims Received	14,094	13,987	12,826	14,415
EDI	11,010	10,879	10,097	11,333
OCR	3,084	3,108	2,729	3,082
$ of Claims paid	$2,911,127	$2,046,700	$2,086,440	$2,634,147
Average Turn Around Time (# of days to check date)				
% of claims within 7 days	75.10%	72.96%	65.69%	74.51%
% of claims within 14 days	96.53%	93.97%	93.00%	95.57%
% of claims within 21 days	98.37%	97.62%	98.63%	98.32%
% of claims within 30 days	98.58%	98.47%	99.00%	98.89%
% of claims within 60 days	98.91%	99.12%	99.69%	99.32%

	Sept	Oct	Nov	Dec	YTD
Claims Received	39,349	38,032	39,490	40,547	169,320
EDI	11,002	11,305	11,999	11,846	132,733
OCR	2,665	2,747	2,612	3,089	36,587
$ of Claims paid	$2,016,261	$2,042,425	$2,992,329	$2,663,290	$28,967,881
Average Turn Around Time (# of days to check date)					
% of claims within 7 days	76.46%	78.19%	65.90%	64.45%	72.46%
% of claims within 14 days	94.35%	96.29%	92.00%	93.75%	93.87%
% of claims within 21 days	97.55%	98.43%	96.82%	97.73%	97.93%
% of claims within 30 days	99.05%	98.99%	98.31%	98.50%	98.61%
% of claims within 60 days	99.40%	99.16%	99.72%	99.02%	99.28%

	Jan	Feb	Mar	Apr
Claims Received	50,891	51,299	58,697	54,500
EDI	33,044	34,158	39,581	36,945
OCR	17,847	17,141	19,116	17,555
$ of Claims paid	$8,406,665	$10,240,267	$14,905,312	$11,815,814
Average Turn Around Time (# of days to check date)				
% of claims within 7 days	65.18%	66.28%	64.99%	71.79%
% of claims within 14 days	94.48%	91.29%	93.00%	96.29%
% of claims within 21 days	99.18%	98.42%	99.06%	99.01%
% of claims within 30 days	99.47%	99.15%	99.54%	99.47%
% of claims within 60 days	99.66%	99.32%	99.69%	99.67%

TENNESSEE MEDICARE	May	June	Jul	Aug
Claims Received	57,240	57,672	53,735	62,382
EDI	39,268	40,999	39,669	46,158
OCR	17,972	16,673	14,066	16,224
$ of Claims paid	$11,499,010	$15,665,648	$10,784,224	$16,258,132
Average Turn Around Time (# of days to check date)				
% of claims within 7 days	67.59%	63.29%	68.01%	69.87%
% of claims within 14 days	96.96%	94.26%	92.52%	95.17%
% of claims within 21 days	99.36%	98.90%	98.57%	97.59%
% of claims within 30 days	99.66%	99.37%	99.14%	98.25%
% of claims within 60 days	99.77%	99.61%	99.47%	98.80%

TENNESSEE MEDICARE	Sept	Oct	Nov	Dec	YTD
Claims Received	60,592	62,768	65,544	63,603	698,923
EDI	45,888	47,890	49,833	47,750	501,183
OCR	14,704	14,878	15,711	15,853	197,740
$ of Claims paid	$11,553,744	$11,513,839	$16,168,541	$13,250,681	$152,061,879
Average Turn Around Time (# of days to check date)					
% of claims within 7 days	74.46%	75.98%	73.21%	66.71%	69.00%
% of claims within 14 days	97.72%	97.41%	95.54%	94.28%	94.91%
% of claims within 21 days	99.50%	99.32%	97.93%	97.70%	98.66%
% of claims within 30 days	99.64%	99.49%	98.38%	98.11%	99.09%
% of claims within 60 days	99.76%	99.79%	98.85%	98.50%	99.37%

The above numbers indicate that the HMO was in compliance with Tenn. Code Ann. § 56-7-109 on commercial and Medicare claims.

Privacy Policy:

The HMO has a written privacy statement that is supplied to its members annually in compliance with Tenn. Comp. R. & Regs., 0780-1-72. Such privacy statement is included on the HMO's website (www.cariten.com) under the section titled "Important Member Information".

Policyholder Complaints:

The HMO has a grievance process in place which does not appear to comply with Tenn. Code Ann. 56-32-210(c)(5) which stipulates that review of each grievance by a grievance committee, "shall be held within ten (10) working days, such extension not to

exceed an additional ten (10) working days." A sample of policyholder complaints and Department inquiries were not answered within the guidelines of the law.

The HMO's complaint register was sampled and reviewed. Grievance letters sent to members were not in compliance with Tenn. Code Ann. 56-32-210(c)(5) providing a name designated to coordinate the grievance review. This issue was referred to management. See the "Comments and Recommendations section" below.

EXCESS LOSS AGREEMENT

Prior to January 1, 2003, the HMO had a reinsurance agreement in place for Senior Health HMO products. It was determined this agreement was not cost beneficial and the coverage ended. At that time, the HMO established a reserve based on the monthly amount approximately equal to the per-member per-month premium rate of the prior catastrophic claim coverage.

RETIREMENT PLAN AND OTHER EMPLOYEE BENEFITS

The HMO has no employees. All business functions are performed by PHP under recitals of a services agreement discussed under the caption, "Agreements with Parent, Subsidiaries and Affiliates". Personnel participate in Covenant's employee benefit plans which are summarized as follows:

Comprehensive Medical	Contributory for employee and dependent(s). Employees may choose from three (3) options, with varying premiums, deductibles and network restrictions. Coverage is effective after ninety (90) days of employment and covers pre-existing conditions.
Vision coverage	Contributory for all employees and dependent(s).
Dental Coverage	Contributory for all employees and dependent(s).
Short Term Disability	Contributory for employee.
Long Term Disability	Non-contributory for employee.
Term Life and Accidental Death And Dismemberment	Non-contributory for employee. Coverage equals one (1) times employee salary. Additional coverage may be purchased.
401(K)	Eligible employees may defer up to nineteen percent (19%) of bi-weekly compensation pre-tax. PHP will match one hundred percent (100%) up to a maximum of six percent (6.0%) of salary. Participants are fully vested

by end of the fifth (5) year of service. Investments are individually directed.

PHP provides a flexible paid leave program. Employees hired before July 1, 2005 earn paid time off (PTO). PTO accrues every bi-weekly pay period.

SCHEDULE OF PTO: Full-time Employees

Years of Service	Annual PTO Days
Date of Hire	18
4th Anniversary	23
7th Anniversary	24
9th Anniversary	25
11th Anniversary	26
13th Anniversary	27
15th Anniversary	28

SCHEDULE OF PTO: Part-time Employees

Years of Service	Maximum Accumulation	Accrual Per Pay Period
Date of Hire	120 Hours	Base Hrs Pd X .04
5th Anniversary	128 Hours	Base Hrs Pd X .05
10th Anniversary	136 Hours	Base Hrs Pd X .06
15th Anniversary	144 Hours	Base Hrs Pd X .07

Employees hired after July 1, 2005 accrue Combined Time Off (CTO) per pay period. Full time employees accumulate hours based on their length of service. Part time employees build up hours based on the number of hours working during a pay period and length of service.

SCHEDULE OF CTO: Full-time Employees

Effective Date	Maximum Accumulation
Date of Hire	230 hours
5th Anniversary	336 hours
10th Anniversary	488 hours

SCHEDULE OF CTO: Part-time Employees

Effective Date	Maximum Accumulation	Pro Rated
Date of Hire	120 hours	Hours worked x .04
5th Anniversary	128 hours	Hours worked x .05
10th Anniversary	136 hours	Hours worked x .06
15th Anniversary	144 hours	Hours worked x .07

LOSS EXPERIENCE

As developed from applicable amounts included in the HMO's annual statements filed with the Department, the ratios of net losses incurred to net premiums earned for the period subject to this examination were as follows:

Year	Medical Expenses Incurred	Net Premiums Earned	Loss Ratio
2001	$60,971,644	$74,993,458	81.3%
2002	$91,834,101	$102,769,246	89.4%
2003	$122,898,442	$131,915,523	93.2%
2004	$160,400,858	$170,880,194	93.9%
2005	$201,232,377	$226,034,936	89.0%
Total	$637,337,422	$706,593,357	90.2%

ACCOUNTS AND RECORDS

During the course of examination, such tests and audit procedures were made as were considered necessary, including substantial verification of postings, extensions and footings and reconciliation of subsidiary ledgers to control accounts where necessary. General ledger trial balances were reconciled with copies of annual statements for the years 2002, 2003, 2004, and 2005.

Accounting records conform to generally accepted insurance accounting practices and appear to properly reflect the operations during the period under examination and the status of the HMO at the date of examination, with the following exceptions, which were referred to management in the "Comments and Recommendations Section" below:

- A money market fund was incorrectly classified as a bond. The fund should be classified under "Cash, cash equivalents, and short-term investments".

- The HMO's stock certificates could not be located for verification.

The HMO files an annual Risk Based Capital Report. Total adjusted capital, post tax at December 31, 2005 was twenty-seven million nine hundred eight thousand ninety dollars ($27,908,090). This amount exceeds the authorized control level risk-based capital amount of eight million three hundred thirty-seven thousand five hundred thirty-six dollars ($8,337,536).

The HMO's Independent Auditors' Report is issued annually by the accounting firm of Pershing Yoakley & Associates.

Books and records of the HMO are kept at the home office location:

1420 Centerpoint Blvd.
Knoxville, Tennessee 37932

STATUTORY DEPOSITS

In compliance with statutory requirements, the HMO maintained the following deposits at December 31, 2005:

Where Deposited and Description	Par Value	Statement Value	Market Value
Tennessee			
USTN 2.625%, due 3/15/2009	$200,000	$197,897	$197,897
USTN 3.500%, due 11/15/2006	$200,000	$202,240	$202,940
USTN 3.000%, due 2/15/2008	$250,000	$252,910	$252,910
USTN 2.625%, due 3/15/2009	$350,000	$343,853	$343,853
USTN 3.000%, due 11/15/2007	$1,100,000	$1,109,606	$1,109,606
Total deposits held for the benefit of all enrollees of the HMO in Tennessee	**$2,100,000**	**$2,106,501**	**$2,106,501**

AGREEMENTS WITH PARENT, SUBSIDIARIES AND AFFILIATES

The HMO is a member of a holding company as defined by Tenn. Code Ann. 56-11-201(b)(c).

Covenant Health is the holding company for the HMO.

The holding company system came into existence during 1995 with Covenant as the holding company. The HMO entered into a services agreement with its parent, PHP effective January 1, 2000. Under this agreement, PHP provides the HMO with employees, office space, equipment, supplies, information services and other services necessary to perform its operating and administrative functions, including, without limitation, claims processing and payment, marketing, compliance, network

management, reporting, record keeping and other administrative services.

The agreement is automatically renewed on the first day of each January for an additional one year term, unless on or before October 1 of the immediately preceding year, one party gives the other written notice of an intention not to renew. A party may terminate the agreement with or without cause upon thirty days (30) days prior written notice to the other parties.

Payment for the items provided and services performed pursuant to the agreement shall be made on a monthly basis. Payment shall be due by the end of the calendar month following the month in which items and services were provided. Payment amounts shall be determined by the Chief Financial Officer of PHP, and payment shall be made by appropriate entries in the books and records of PHP and of the subsidiary.

During the last examination the services agreement did not contain the approval stamp of the Commissioner pursuant to the Tenn. Code Ann. § 56-11-206(2)(D). The HMO submitted the services agreement to the Department on July 10, 2003. Department approval was given on September 23, 2003.

The HMO is a party to a consolidated Tax Allocation Agreement between PHP and its subsidiaries. The HMO signed the agreement effective April 1, 1999. The tax liability of the group will be apportioned among the members of the affiliated group in accordance with a ratio, which would be attributable to each member having a taxable income. A member's portion of the tax liability is equal to the tax liability of the group multiplied by a fraction, as noted in the tax allocation agreement.

In the event of a refund, PHP would allocate the refund in a manner consistent with the allocations of income, deductions and credits made after the re-computation of each member's federal income tax liability for the tax year that generated the refund. Departmental approval was given on September 23, 2003.

PECUNIARY INTEREST - TENN. CODE § 56-3-103

Directors and Executive Officers filed conflict of interest statements stating an understanding of Coventant Health Conflict of Interest policies. Such policies require the individual to disclose any potential conflict as they arise. No conflicts with regards to pecuniary interests have been disclosed.

COMMISSION EQUITY

There is no excess of loss agreement in effect at December 31, 2005. Therefore, no commission equity could exist.

DIVIDENDS OR DISTRIBUTIONS

During 2003, the HMO returned contributed capital to its parent company. Such distributions were concluded to be an extraordinary distribution or dividend. Under Tenn. Code Ann. § 56-11-206(b)(2), the HMO was statutorily obligated to provide notice to the Commissioner of Commerce and Insurance. A cease and desist order was levied on the HMO for these actions. Subsequently, the parent returned the contributed capital back to the HMO.

No dividend or distribution has taken place since this time to December 31, 2005.

LITIGATION

As of December 31, 2005, the HMO was not currently involved in any legal proceeding which was deemed to be material.

SUBSEQUENT EVENTS

During the examination, the custodial agreement was found to need revisions. The HMO submitted a revised custodial agreement, which was approved on December 5, 2006.

The HMO's bylaws remained in a previous entity's name. Currently, the HMO has implemented plans to change the bylaws with subsequent approval at the March 2007 Board of Directors meeting.

The HMO's stock certificate book could not be located. Currently, the HMO has taken steps to reissue stocks with subsequent approval at the March 2007 Board of Directors meeting.

Cariten Healthcare implemented a customer discount program for its members. This program gives employer groups with Cariten an opportunity to reach out to other members through product and service discounts. Involvement into the program is voluntary. Program details are provided on the Cariten website (www.cariten.com).

Membership in 2006 has increased approximately thirty-two percent (32%) from 41,547 members at yearend to 54,844 members at the end of the third quarter in 2006. The majority of the new members were dually eligible under the PHP TennCare plan and the Medicare Advantage plan. Members were given advance notice of the disenrollment from TennCare and enrollment into Cariten's Medicare Advantage plan.

FINANCIAL STATEMENT

There follows a statement of assets, liabilities and statement of income at December 31, 2005, together with a reconciliation of capital and surplus for the period under review, as established by this examination:

ASSETS

	Ledger Assets	Non-Ledger Assets	Assets Not Admitted	Net Admitted Assets
Bonds	$69,613,179			$69,613,179
Cash (cash = 5,235,872, cash equivalents = 0, short-term investments = 574,508)	5,810,380			5,810,380
Investment income due and accrued	961,993			961,993
Uncollected premiums and a gents' balances in the course of collection	294,150		42,556	251,594
Net deferred tax asset	467,440		467,440	0
Receivables from parent, subsidiaries and affiliates	6,707,520		6,707,520	0
Totals	$83,854,662		$7,217,516	$76,637,146

LIABILITIES, SURPLUS, AND OTHER FUNDS

	Covered	Uncovered	Total
Claims unpaid	$27,408,954	$905,665	$28,314,619
Unpaid claim adjustment expenses	725,600		725,600
Aggregate health policy reserves	815,864		815,864
Premiums received in advance	445,695		445,695
General expenses due or accrued	316,443		316,443
Amounts due to parent, subsidiaries and affiliates	265,750		265,750
Aggregate write-ins for other liabilities (including Reserve for Transplants $3,121,300; Risk Amount Payable $2,379; Unclaimed Property $30,809; Pharmacy Payable $1,311,320; Reserve for Catastrophic Claims $4,982,864; Contingency Reserve for Run Out Cost $8,606,719)	18,055,391		18,055,391
Total Liabilities	$48,033,697	$905,665	$48,939,362
Common capital stock			$100,000
Gross paid in and contributed surplus			$31,214,528
Unassigned funds (surplus)			(3,616,744)
Total capital and surplus			$27,697,784
Totals			$76,637,146

STATEMENT OF REVENUE AND EXPENSES

	Uncovered	Total
Member months	0	464,688
Net premium income	XXX	$226,034,936
Aggregate write-ins for other health care related revenues		178,425
Total revenues	XXX	$226,213,361
MEDICAL AND HOSPITAL		
Hospital/medical benefits	$905,665	$184,113,310
Other professional services		2,366,591
Emergency room and out of area		4,072,243
Prescription drugs		11,508,906
Aggregate write-ins for other medical and hospital		(828,673)
Subtotal	$905,665	$201,232,377
LESS		
Total medical and hospital	$905,665	$201,232,377
Claims adjustment expenses		1,710,356
General administrative expenses		11,805,284
Total underwriting deductions	$905,665	$214,748,017
Total underwriting gain or (loss) (Total revenue less Total underwriting deductions)	XXX	$11,465,344
Net Investment income earned		3,173,168
Net realized capital gains or losses		(21,905)
Net investment gains or (losses)		$3,151,263
Net income or (loss) before income taxes (Total underwriting gain or (loss) plus Net investment gains or (losses))		$14,616,607
Federal income taxes incurred		$6,686,526
Net income (Net income or (loss) before income taxes minus Federal income taxes incurred)		$7,930,081

CAPITAL AND SURPLUS ACCOUNT

Surplus as regards policyholders, December 31 prior year		$26,978,082
Net income	$7,930,081	
Change in non-admitted assets	(7,182,728)	
Aggregate write-ins for gains or (losses) in surplus (including Change in Unrealized Valuation ($35,946))	(27,651)	
Change in surplus as regards policyholders for the year		719,702
Surplus as regards policyholders, December 31 current year		$27,697,784

RECONCILIATION OF CAPITAL AND SURPLUS
FOR THE PERIOD UNDER EXAMINATION

	2001	2002	2003	2004	2005
Surplus as regards policyholders December 31, Previous Year	$7,337,554	$17,539,500	$17,083,624	$23,607,399	$26,978,082
Net Income	7,760,330	5,103,943	2,125,974	1,343,904	7,930,081
Net unrealized capital gains and (losses)	0	0	0	0	0
Change in net deferred income tax	0	0	0	0	0
Change in non-admitted assets	(558,384)	(5,559,819)	4,176,317	2,026,779	(7,182,728)
Cumulative effect of changes in accounting principles	0	0	0	0	0
Surplus adjustments: paid in	3,000,000	0	221,484	0	0
Dividends to stockholders	0	0	0	0	0
Aggregate Write ins for gains or (losses) in surplus	0	0	0	0	(27,651)
Surplus as regards to policyholders December 31 Current Year	**$17,539,500**	**$17,083,624**	**$23,607,399**	**$26,978,082**	**$27,697,784**

ANALYSIS OF CHANGES IN FINANCIAL STATEMENT AND COMMENTS RESULTING FROM EXAMINATION

Item	Amount
Bonds	($324,508)
Cash, cash equivalents and short-term investments	$324,508

The above amount reflects a reclassification of three hundred twenty-four thousand five hundred eight dollars ($324,508) from "Bonds" to "Cash, cash equivalents, and short-term investments" in the annual statement. On December 31, 2005, the HMO listed on Schedule D – Part 1 a bond named Northern Trust Money Market Fund. Such investment should be classified under "Cash, cash equivalent, and short-term investments".

Under Statutory Accounting Practices and Procedures No. 2 - Cash, Drafts, and Short-term Investments, Paragraph No. 10, "Short-term investments include, but are not limited to, bonds, commercial paper, money market instruments, repurchase agreements, and collateral and mortgage loans which meet the above criteria."

SUMMARY SCHEDULE FOR "ANALYSIS OF CHANGES IN FINANCIAL STATEMENT AND COMMENTS RESULTING FROM EXAMINATION" AS THEY AFFECT SURPLUS

Item	Surplus	
	Increase	Decrease
Bonds		$324,508
Cash, cash equivalent and short-term investments	$324,508	
Totals	$324,508	$324,508
Net change in surplus		$0

COMMENTS AND RECOMMENDATIONS

Comments:

- As noted in the last examination and the "Charter and Bylaws" section above, the HMO's bylaws remained in a previous entity's name. Currently, the HMO has implemented plans to change the bylaws with subsequent approval at the March 2007 Board of Directors meeting.

Recommendations:

- The HMO should implement a consistent system for responding to all grievances, including Department inquiries (See the "Market Conduct Activities" section above). This system should comply with Tenn. Code Ann. § 56-32-210(c)(5) which stipulates that review of each grievance by a grievance committee, "shall be held within ten (10) working days, such extension not to exceed an additional ten (10) working days."

- An inquiry made by the Department noted the HMO's Physicians' manual and the provider contracts need to be updated as required to Tenn. Code Ann. 56-32-203(b)(4) and (c)(1), as noted in the "Market Conduct Activities" section above.

- No approval was given for the HMO's transactions and events in the Board of Director minutes pursuant to Tenn. Code Ann. 56-3-408(b)(1), as noted in the "Corporate Records" section above.

CONCLUSION

Insurance examination practices and procedures, as promulgated by the NAIC, have been followed in connection with the verification and valuation of assets and the determination of liabilities of Cariten Health Plan Inc. of Knoxville, Tennessee.

In such manner, it was determined that, as of December 31, 2005, the HMO had admitted assets of seventy-six million six hundred thirty-seven thousand one hundred forty-six dollars ($76,637,146) and liabilities, exclusive of capital, of forty-eight million nine hundred thirty-nine thousand three hundred sixty-two dollars ($48,939,362). Thus, there existed for the additional protection of the policyholders/enrollees, the amount of twenty-seven million six hundred ninety-seven thousand seven hundred eighty-four dollars ($27,697,784) in the form of common capital stock, gross paid-in and contributed surplus, surplus notes and unassigned funds (surplus).

The above amount of net worth does comply with the amount required pursuant to Tenn. Code Ann. § 56-32-212. At December 31, 2005, the required net worth under the referenced statute is seven million one hundred forty thousand five hundred twenty-four dollars ($7,140,524).

The courteous cooperation of the HMO's officers and PHP employees extended during the course of the examination is hereby acknowledged.

Respectfully submitted,

Brian H. Sewell

Brian H. Sewell, CFE
Insurance Examiner
State of Tennessee
Southeastern Zone, N.A.I.C.

AFFIDAVIT

The undersigned deposes and says that he has duly executed the attached examination report of Cariten Health Plan Inc. dated January 16, 2007 and made as of December 31, 2005, on behalf of The Department of Commerce and Insurance, State of Tennessee. Deponent further says he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.

Brian H. Sewell

Brian H. Sewell, CFE
Insurance Examiner
State of Tennessee
Southeastern Zone, N.A.I.C.

Subscribed and sworn to before me

this 11TH day of

June, 2007

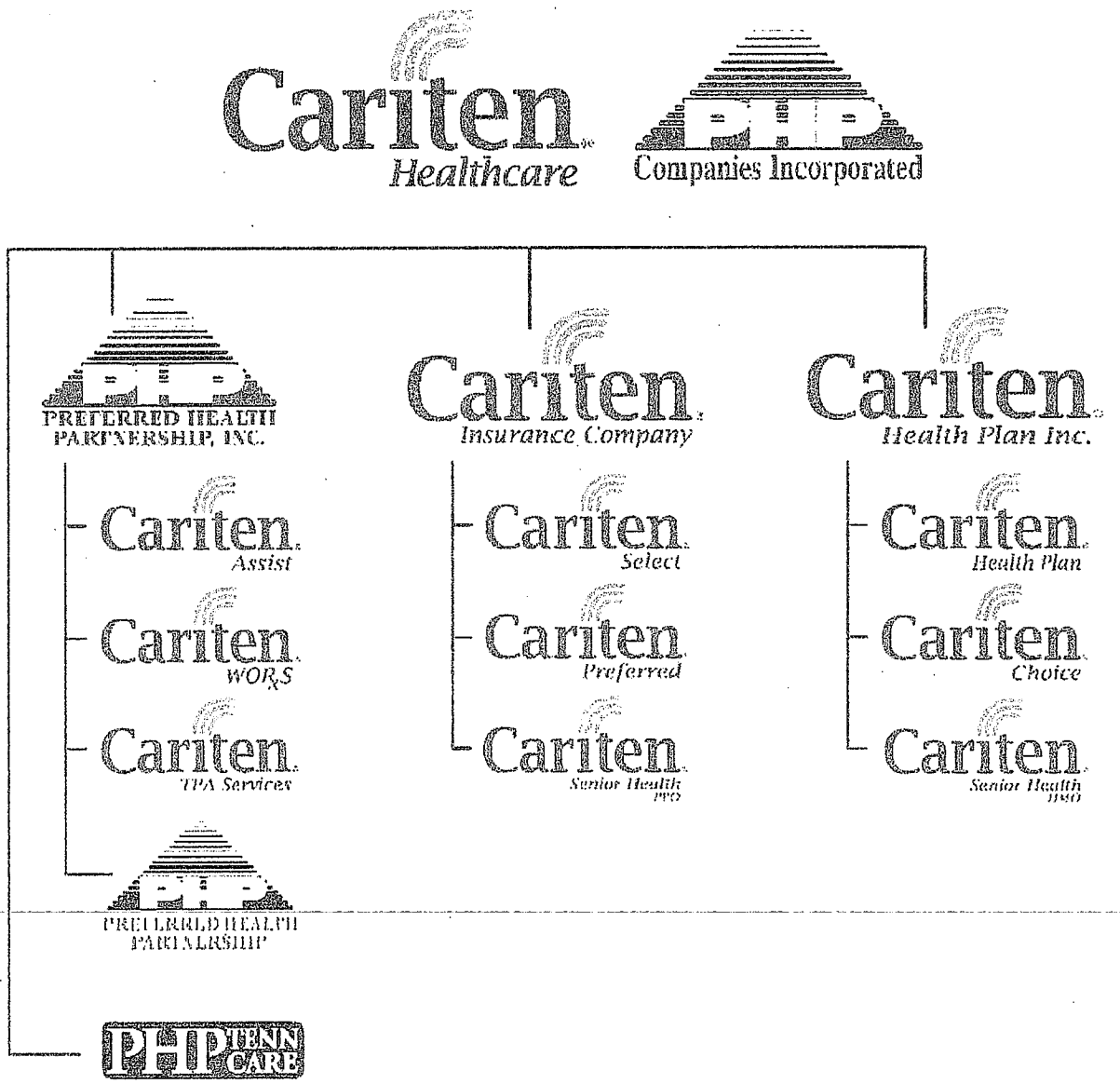
Notary Kristina D Rust

County Davidson

State Tennessee

Commission Expires 7/19/08

ORGANIZATIONAL CHART



June 21, 2007

State of Tennessee
Department of Commerce & Insurance
Attn: Philip Blustein, CFE
500 James Robertson Pkwy
Nashville, TN 37243

RE: Financial Condition Examination of
Cariten Health Plan
Made as of December 31, 2005

Dear Mr. Blustein,

Enclosed you will find the response to the Financial Condition Examinations as well as supporting documentation.

- Comments, page 27 – "As noted in the last examination and the "Charter and Bylaws" section above, the HMO's bylaws remained in a previous entity's name. Currently, the HMO has implemented plans to change the bylaws with subsequent approval at the March 2007 Board of Directors meeting."

Cariten Health Plan concurs that the company bylaws should be updated. Attorneys are currently in the process of updating the bylaws.

- Recommendations, page 27 - "The HMO should implement a consistent system for responding to all grievances, including Department inquiries (See the "Market Conduct Activities" section above.) This system should comply with Tenn. Code Ann. § 56-32-210(c)(5) which stipulates that review of each grievance by a grievance committee, "shall be held within ten (10) working days, such extension not to exceed an additional ten (10) working days."

Cariten Health Plan has implemented several new policies and technologies to meet the required resolution of a grievance within 10 days. Please see the enclosed policies and flowchart.

- Policyholder Complaints, page 14 – "The HMO's complaint register was sampled and reviewed. Grievance letters sent to members were not in compliance with Tenn. Code Ann. 56-32-210(c)(5) providing a name designated to coordinate the grievance review."

EXHIBIT
tabbies B

RECEIVED
JUN 27 2007
Financial Affairs
Analytical Unit

Cariten Health Plan concurs that the names of the Grievance Coordinator were not indicated on the letters. The Appeal Department has updated the HMO grievance letters to include the name of the Grievance Coordinator that processed the grievance. Please see the enclosed letter templates.

- Recommendations, page 27 – "An inquiry made by the Department noted the HMO's Physicians' manual and the provider contracts need to be updated as required to Tenn. Code Ann. 56-32-203(b)(4) and (c)(1), as noted in the "Market Conduct Activities" section above.

Cariten Health Plan's commercial contracts for HMO have undergone no modifications in language that were material changes since they were approved in 2000. We are, however, preparing the contracts and the provider reference manual for submittal to the Department of Commerce and Insurance since it has been sometime since the contracts were reviewed. Our attorney has recently reviewed the contracts and that applicable state law and found no deficiencies in our contracts.

- Recommendations, page 27 – "No approval was given for the HMO's transactions and event in the Board of Director minutes pursuant to Tenn. Code Ann. 56-3-408(b)(1), as noted in the "Corporate Records" section above.

Cariten Health Plan does not agree with the assertion that the HMO's financial transactions are not approved by its Board of Directors. The Board of Directors has approved a set of investment fund guidelines. The guidelines delegate authority and responsibility of investment management to PHP management through the Investment Manager and in conjunction with executive leadership of Covenant Health. State statute 56-3-408(b)(1) allows for the board to appoint a committee to approve investment transactions. The HMO's management contends that the delegation of authority in the investment fund guidelines qualifies as the appointment of a committee.

Should you have additional questions you may reach me at (865) 670-7830.

Sincerely,

Kristy L. Lund

Kristy Lund
Accountant
Cariten Health Plan

Enclosures