Report on Examination

of

Total Health Choice, Inc.

Miami, Florida

as of

December 31, 2004

By The
State of Florida
Office of Insurance Regulation

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Tallahassee, Florida

June 19, 2006

Kevin M. McCarty, Commissioner
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399-0326

Dear Sir:

Pursuant to your instructions, in compliance with Section 641.27, Florida Statutes (F.S.), and in accordance with the practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC), we have conducted an examination as of December 31, 2004, of the financial condition and corporate affairs of:

Total Health Choice, Inc.
8701 S.W. 137th Avenue, Suite 200
Miami, Florida 33183

hereinafter generally referred to as the "Plan". Such report of examination is herewith respectfully submitted.

SCOPE OF EXAMINATION

This examination covered the period of January 1, 2002 through December 31, 2004. The Plan was last examined by the Florida Office of Insurance Regulation (the "Office") as of December 31, 2000. In lieu of conducting a statutory financial condition examination of the Plan for the year 2001, the Office accepted the independent certified public accountant's (CPA) audit report on the Plan's statutory-basis financial statements for that year pursuant to Section 641.27(1), F.S.

Planning for the current examination began on January 3, 2006. The fieldwork commenced on January 9, 2006 and concluded on March 31, 2006. The examination included any material transactions and/or events occurring subsequent to the examination date and noted during the course of the examination.

This was a statutory financial condition examination conducted in accordance with the NAIC *Financial Examiners Handbook, Accounting Practices and Procedures Manual*, and *Annual Statement Instructions*, with due regard to the requirements of the insurance laws and rules of the State of Florida.

In this examination, emphasis was directed to the quality, value, and integrity of the statement assets and the determination of liabilities, as they affect the Plan's solvency.

The examination included a review of corporate and other selected records deemed pertinent to the Plan's operations and practices. In addition, various ratio results, *Best's Insurance Reports*, the Plan's independent audit reports, and certain work papers prepared by the Plan's independent CPA were reviewed and utilized where applicable within the scope of this examination.

We valued and/or verified the Plan's assets and liabilities as reported by the Plan in its 2004 annual statement. Transactions subsequent to December 31, 2004 were reviewed where relevant and deemed significant to the Plan's financial condition.

This report of examination is confined to financial statements and comments on matters that involve departures from laws, regulations or rules, or which require special explanation or description.

STATUS OF ADVERSE FINDINGS FROM PRIOR EXAMINATION

The following is a summary of significant adverse findings included in the Office's prior examination report as of December 31, 2000, along with resulting action taken by the Plan in connection therewith.

MANAGEMENT AGREEMENT

On January 15, 1997, the Plan entered into a management agreement with Universal Health Management, LLC ("Universal"), a Michigan limited liability company. According to the terms of the agreement, Universal was to provide management services, employees, office equipment, supplies, furnishings, and office space as it determined reasonably necessary or appropriate for the effective management of the Plan. Universal and the Plan shared certain common officials and members of management. As of December 31, 2000, the Office considered the two companies to be affiliates, as defined by Section 641.19(1), F.S. However, the Plan failed to report Universal as an affiliate to the Office and to disclose related party transactions between them in its 2000 annual statement. Resolution: The Plan and Universal no longer share common officials or members of management, the contractual relationship between them was revised, and they are no longer considered affiliates.

OFFICERS AND DIRECTORS

The Plan failed to disclose the names of all of its officers and directors in its 2000 annual statement as required. It was directed to properly disclose in its annual statement the names of all of its officers and directors in accordance with the NAIC *Annual Statement Instructions*. Resolution: The Plan complied with the directive.

CUSTODIAL AGREEMENT

The Plan's investments were held by banks and trust company custodians; however, there were no executed custodial agreements with the custodians, as recommended by the NAIC. The Plan was directed to enter into proper custodial agreements containing the appropriate indemnification clauses, as recommended by the NAIC. Resolution: The Plan complied with the directive.

CONFLICT OF INTEREST PROCEDURE

At December 31, 2000, the Plan did not have a policy statement on conflicts of interest, pursuant to Section 617.0832, F.S. Resolution: The Plan adopted a conflict of interest policy statement on March 1, 2001.

HISTORY

GENERAL

The Plan, formerly known as "PacifiCare of Florida, Inc.", received its original certificate of authority as a Florida health maintenance organization (HMO) on September 15, 1986. On March 25, 1997, its name was changed to "Total Health Choice, Inc." On December 18, 1997, the Plan converted from a Florida for profit corporation to a Florida not for profit corporation, which it remains.

As of the date of this examination, the Plan was authorized to transact business as an HMO in accordance with Part I of Chapter 641, F.S.

The Plan's articles of incorporation were not amended during the period covered by this examination. Its bylaws were amended on March 24, 2006.

CORPORATE MEMBERSHIP

The Plan is a Florida not for profit corporation. Its sole member is Total Health Care, Inc. An organizational chart appears on page 7.

PROFITABILITY

For the period of this examination, the Plan reported the following:

($ Millions)	2004	2003	2002
Net premiums	$45.0	$46.9	$37.9
Total revenues	$45.0	$46.9	$37.9
Net income	($1.2)	$1.4	($0.2)
Total capital & surplus	$4.2	$4.8	$2.8

MANAGEMENT

The annual shareholder meeting for the election of directors was held in accordance with Sections 617.0701 and 628.231, F.S. Directors serving as of December 31, 2004 were:

Directors

Name and Location	Principal Occupation
Jeanette Abbott Detroit, Michigan	Retired
Douglas P. Baker Clarkston, Michigan	Chief Financial Officer of NAND-Proprietary, Inc.
Mary J. Clay Detroit, Michigan	Treasurer of Total Health Choice, Inc.
Ruby O. Cole Detroit, Michigan	Nurse
Kathleen T. Kather Oakland, Michigan	Retired
Frances Lynch Detroit, Michigan	Retired
Gertrude H. Minkiewicz Sterling Heights, Michigan	Retired

At December 31, 2004, the principal committee of the Board was the Finance Committee, the members of which were:

Finance Committee

Jeanette Abbott
Douglas P. Baker
Mary J. Clay

The following were the Plan's senior officers as of December 31, 2004, as appointed by its board of directors in accordance with the Plan's bylaws:

Senior Officers

Name	Title
Lyle E. Algate	Chief Executive Officer
Robyn J. Arrington, Jr., M.D.	Chief Medical Officer
Mary J. Clay	Treasurer

CONFLICT OF INTEREST PROCEDURE

The Plan adopted a policy statement requiring annual disclosure of conflicts of interest in accordance with Section 617.0832, F.S. No exceptions were noted during this examination.

CORPORATE RECORDS

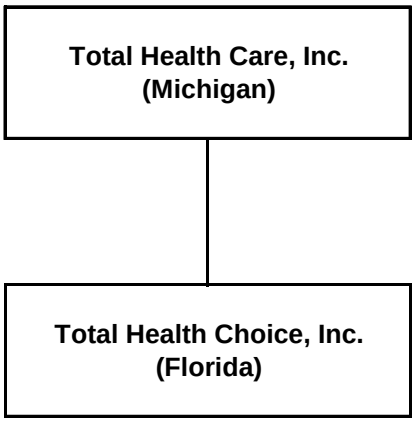
The recorded minutes of the member, Board of Directors, and Finance Committee meetings were reviewed for the period examined. The recorded minutes of the Board adequately documented its meetings and approval of Plan transactions in accordance with Section 617.1601, F.S., including the authorization of investments as required by Section 641.35(7), F.S.

AFFILIATED COMPANIES

The Plan was a member of an insurance company holding system as defined by Rule 69O-143.045(3), Florida Administrative Code (F.A.C.).

An organizational chart as of December 31, 2004 reflecting the holding company system is shown below.

Total Health Choice, Inc.
Organizational Chart
December 31, 2004



FIDELITY BOND AND OTHER INSURANCE

The Plan maintains acceptable levels of general liability insurance in compliance with Rule 69O-191.069, F.A.C., and maintains a blanket fidelity bond in the amount of $1 million as required by Section 641.22, F.S. As an individual practice association (IPA) model HMO, the Plan maintains adequate professional liability insurance. It requires in its provider contracts that its providers certify and maintain appropriate levels of medical malpractice insurance or its equivalent in compliance with Rule 69O-191.069, F.A.C.

PENSION, STOCK OWNERSHIP, AND INSURANCE PLANS

The Plan has no direct employees of its own and, therefore, has no employee benefit plans.

STATUTORY DEPOSITS

The Plan maintained on deposit with the Office an insolvency protection deposit of $500,000 in accordance with Section 641.285, F.S., and a Rehabilitation Administrative Expense Fund deposit of $10,000 in accordance with Section 641.227, F.S.

INSURANCE PRODUCTS AND RELATED PRACTICES

TERRITORY AND PLAN OF OPERATION

At December 31, 2004, the Plan was authorized to transact business in Florida as an HMO in accordance with Part I of Chapter 641, F.S. It holds a current health care provider certificate issued by the Florida Agency for Health Care Administration, pursuant to Part III of Chapter 641, F.S., which is valid until March 19, 2008.

The Plan used a network of general agents and brokers, and operated as an individual practice association (IPA) model. It provided health care services to individual and group comprehensive members. Its total membership at December 31, 2004 was 14,980.

The Plan operates in the Florida counties of Broward, Miami-Dade, and Palm Beach.

TREATMENT OF MEMBERS

The Plan established procedures for handling written complaints in accordance with Section 641.511, F.S., and maintained a claims procedure manual that included detailed procedures for handling each type of claim.

REINSURANCE

The Plan maintained a specific excess loss reinsurance agreement with Allianz Life Insurance Company of North America, Inc., a Minnesota insurer authorized in Florida, which was last renewed on November 11, 2004. The agreement provides for reimbursement of up to $2 million on eligible paid losses in excess of $200,000. The agreement was filed and approved by the Office. The reinsurance contracts were reviewed by the Plan's appointed actuary and utilized in determining the ultimate loss opinion.

ACCOUNTS AND RECORDS

An independent CPA audited the Plan's statutory-basis financial statements annually for years 2002, 2003, and 2004, pursuant to Section 641.26(1)(c), F.S.

The Plan's accounting records were maintained on a computerized system. Its balance sheet accounts were verified with the line items of its annual statement submitted to the Office.

The Plan's main administrative office is located in Miami, Florida, where this examination was conducted.

The following agreements were in effect between the Plan and non-affiliates:

PROVIDER AND PHYSICIAN AGREEMENTS

The Plan contracted with various health care providers in order to procure health care services for its subscribers.

PHARMACY MANAGEMENT AGREEMENT

The Plan contracted with a pharmaceutical management company to provide management and administrative services related to its prescription drug benefits plans. Fees related to this agreement were $50,000, $42,000, and $47,000 in years 2004, 2003, and 2002, respectively.

CUSTODIAL AGREEMENT

The Plan contracted with a major financial institution to maintain custody of its investments. Fees related to this agreement were $86,000, $40,000, and $39,000 in years 2004, 2003, and 2002, respectively.

INDEPENDENT AUDITOR AGREEMENT

The Plan contracted with Plante & Moran, PLLC, to audit its statutory-basis financial statements. Fees related to the agreement were $30,000, $40,000, and $40,000 in years 2004, 2003, and 2002, respectively.

INFORMATION TECHNOLOGY AGREEMENT

The Plan maintained a contract with CSC Healthcare Systems, Inc. to provide hardware and health care software systems to the Plan, pursuant to a July 23, 1993 agreement. Fees related to the agreement were $209,000, $96,000, and $77,000 in years 2004, 2003, and 2002, respectively.

EMPLOYEE STAFFING AND PURCHASED SERVICES AGREEMENT

On June 1, 2002, the Plan contracted with Universal for administrative and personnel services. All of the Plan's personnel are provided by Universal pursuant to this arrangement. Fees related to the agreement were $7.6 million, $7.6 million, and $6.0 million in years 2004, 2003, and 2002, respectively.

FINANCIAL STATEMENTS PER EXAMINATION

The following four pages contain statements of the Plan's financial position at December 31, 2004, as determined by this examination, and the results of its operations for the year then ended as reported by the Plan. Adjustments resulting from this examination are summarized on page 19.

Total Health Choice, Inc.
Assets
December 31, 2004

Classification	Per Company	Examination Adjustments	Per Examination
Bonds	$100,000	$0	$100,000
Cash, cash equivalents, and short-term investments	10,071,051	0	10,071,051
	10,171,051	0	10,171,051
Investment income due and accrued	210	0	210
Uncollected premiums and agents' balances in the course of collection	379,029	(183,442)	195,587
Health care and other amounts receivable	175,365	(50,000)	125,365
Totals	$10,725,655	($233,442)	$10,492,213

Total Health Choice, Inc.
Liabilities, Capital and Surplus
December 31, 2004

Liabilities	Per Company	Examination Adjustments	Per Examination
Claims unpaid	$4,701,792	$0	$4,701,792
Accrued medical incentive pool and bonus amounts	50,400	0	50,400
Unpaid claims adjustment expenses	87,683	0	87,683
Premiums received in advance	1,525,031	0	1,525,031
General expenses due or accrued	178,547	0	178,547
Total liabilities	6,543,453	0	6,543,453
Capital and Surplus			
Gross paid in and contributed surplus	9,819,679	0	9,819,679
Unassigned funds (surplus)	(5,637,477)	(233,442)	(5,870,919)
Total capital and surplus	4,182,202	(233,442)	3,948,760
Total liabilities, capital and surplus	$10,725,655	($233,442)	$10,492,213

Total Health Choice, Inc.
Statement of Revenue and Expenses
For the Year Ended December 31, 2004

Net premium income		$45,035,537
Hospital/medical benefits	$30,949,625	
Other professional services	1,853,866	
Emergency room and out-of-area	1,416,502	
Prescription drugs	2,786,672	
Aggregate write-ins for other hospital and medical	118,506	
Incentive pool, withhold adjustments and bonus amounts	51,688	
	37,176,859	
Net reinsurance recoveries	(241,961)	
Total hospital and medical	36,934,898	
Claims adjustment expenses	191,095	
General administrative expenses	9,363,628	
Total underwriting deductions		46,489,621
Net underwriting gain or (loss)		(1,454,084)
Net investment income earned		85,668
Aggregate write-ins for other income or expenses		148,887
Net income (loss)		($1,219,529)

Total Health Choice, Inc.
Capital and Surplus Account
For the Year Ended December 31, 2004

Capital and surplus, December 31, 2003		$4,794,762
Net income (loss)	($1,219,529)	
Change in non-admitted assets	606,969	
	(612,560)	
Examination adjustments	(233,442)	
		(846,002)
Capital and surplus, December 31, 2004		$3,948,760

COMMENTS ON FINANCIAL STATEMENTS

ASSETS

Uncollected Premiums and Agents' Balances in the Course of Collection $195,587

The amount reported by the Plan in its 2004 annual statement has been reduced by $183,442 to $195,587. The Plan reported as an admitted asset uncollected premiums in the amount of $183,442 which were more than 3 months past due, in violation of Section 641.35(1)(c), F.S. As a result, the asset has been nonadmitted to the extent of $183,442.

Health Care and Other Amounts Receivable $125,365

The amount reported by the Plan in its 2004 annual statement has been reduced by $50,000 to $125,365. The Plan reported as an admitted asset collateral funds deposited with an unaffiliated hospital provider in the amount of $50,000. Such amount would qualify as an admitted asset only if the requirements of Statement of Statutory Accounting Principles (SSAP) No. 84 were satisfied, including the requirement that the Plan perform quarterly reconciliations and settlements of the asset. Because the Plan was unable to demonstrate that the requirements of SSAP No. 84 were satisfied with respect to the asset, it has been nonadmitted in the amount of $50,000.

LIABILITIES

Claims Unpaid; Accrued Medical Incentive Pool and Bonus Amounts; & Unpaid Claims Adjustment Expenses **$ 4,839,875**

An outside actuarial firm appointed by the Board of Directors rendered an opinion that the amounts carried in the Plan's balance sheet as of December 31, 2004 reasonably provided for all unpaid loss and loss expense obligations of the Plan under the terms of its policies and agreements. The Office actuary reviewed work papers provided by the Plan and concurred with this opinion. Based on the results of the Office actuary's review and analysis of work papers and data provided by the Plan, we concluded that the aggregate liability was not materially misstated.

Total Health Choice, Inc.
Comparative Analysis of Changes in Capital and Surplus
December 31, 2004

The following is a reconciliation of total capital and surplus between that reported by the Plan and as determined by the examination.

	Per Company	Per Exam	Increase (Decrease) in Surplus	
Capital & Surplus - December 31, 2004, per annual statement				$4,182,202
Uncollected premiums and agents' balances in the course of collection	$379,029	$195,587	($183,442)	
Health care and other amounts receivable	$175,365	$125,365	($50,000)	
				(233,442)
Capital & Surplus - December 31, 2004, per examination				$3,948,760

SUMMARY OF FINDINGS

COMPLIANCE WITH PREVIOUS DIRECTIVES

The Plan has taken the necessary actions to comply with the comments contained in the financial condition examination report as of December 31, 2000 issued by the Office.

CURRENT EXAMINATION COMMENTS AND CORRECTIVE ACTION

The following is a brief summary of items of interest and corrective action to be taken by the Plan regarding findings of the examination as of December 31, 2004.

Uncollected Premiums and Agents' Balances in the Course of Collection

As discussed on page 17, the Plan reported as an admitted asset uncollected premiums in the total amount of $183,442 which were more than 3 months past due, in violation of Section 641.35(1)(c), F.S. **We recommend that the Plan report as admitted assets only those which comply with the requirements of Section 641.35, F.S.**

Health Care and Other Amounts Receivable

The Plan reported as an admitted asset collateral funds deposited with an unaffiliated hospital provider in the amount of $50,000, as discussed on page 17. Such amount would qualify as an admitted asset only if the requirements of SSAP No. 84 were satisfied, including the requirement that the Plan perform quarterly reconciliations and settlements of the asset. The Plan was unable to demonstrate that the requirements of SSAP No. 84 were satisfied with respect to the asset. **We recommend that the Plan comply with the provisions of SSAP No. 84.**

CONCLUSION

The customary insurance examination practices and procedures as promulgated by the NAIC have been followed in ascertaining the financial condition of **Total Health Choice, Inc.** as of December 31, 2004, consistent with the insurance laws of the State of Florida.

Per examination findings, the Plan's total capital and surplus was $3,948,760, which was in compliance with Section 641.225, F.S. Its required minimum capital and surplus at December 31, 2004 was $1.5 million.

In addition to the undersigned, Russell K. Judge, Financial Examiner/Analyst, Richard Tan, Actuary, and David C. Schleit, CPA, Financial Examiner/Analyst Supervisor, participated in this examination.

Respectfully submitted,

Robert Y. Meszaros
Financial Specialist
Florida Office of Insurance Regulation