REPORT OF
MARKET CONDUCT EXAMINATION
OF

FORTIS INSURANCE COMPANY
Milwaukee, Wisconsin

AS OF
May 24, 2004

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: August 3, 2004

FORTIS INSURANCE COMPANY

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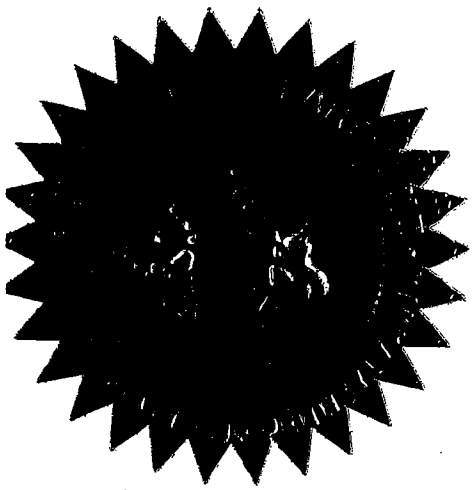
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 29 day of April, 2002, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Randolph L. Rohrbaugh, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



M. Diane Koken
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
FORTIS INSURANCE COMPANY 501 West Michigan Street Milwaukee, WI 53203	:	Sections 605, 606, 623 and 903(a) of the Insurance Department Act, Act of May 17, 1921, P.L. 789, No. 285 (40 P.S. §§ 235, 236, 253 and 323.3)
	:	
	:	Sections 2141 and 2166(A) and 2166(B) of the Act of June 17, 1998, P.L. 464, No. 68 (40 P.S. §§ 991.2141 and 991.2166)
	:	
	:	Sections 81, 617 and 634 of the Insurance Company Law, Act of May 17, 1921, P.L. 682, No. 284 (40 P.S. §§ 771,752(a)(9) and 764e)
	:	
	:	Section 4 of The Health Care Insurance Portability Act of June, 1997, P.L. 295, No. 29 (40 P.S. § 1302.4)
	:	
	:	Act 191, Medical Foods Insurance Coverage (40 P.S. § 3901)
	:	
	:	Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)
	:	
	:	Title 31, Pennsylvania Code, Sections 88.101, 88.103, 146.5, 146.6 and 154.18(c)
	:	
	:	
Respondent.	:	Docket No. MC04-07-026

CONSENT ORDER

AND NOW, this 3RD day of AUGUST, 2004, this Order is hereby issued by the Deputy Insurance Commissioner of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Deputy Insurance Commissioner finds true and correct each of the following Findings of Fact:

(a) Respondent is Fortis Insurance Company, and maintains its address at 501 West Michigan Street, Milwaukee, Wisconsin 53203.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from July 1, 2001 through June 30, 2002, unless otherwise noted.

(c) On May 24, 2004, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on June 24, 2004.

(e) After consideration of the June 24, 2004 response, the Insurance Department has modified the Examination Report as attached.

(f) The Examination Report notes violations of the following:

(i) Section 605 of the Insurance Department Act (40 P.S. § 235), which prohibits an agent from doing business on behalf of any entity without a written appointment; requires all appointments be obtained by procedures established by the Insurance Department; requires the insurer to certify to the Department the names of all appointed agents; and the proper fees be paid by the entity appointing the agent;

(ii) Section 606 of the Insurance Department Act, No. 285 (40 P.S. § 236), which requires all entities to report to the Department all appointments and terminations of appointments in the format and time frame required by the Department's regulations;

(iii) Section 623 of the Insurance Department Act (40 P.S. § 253), which prohibits doing business with unlicensed brokers;

(iv) Section 903(a) of the Insurance Department Act (40 P.S. § 323.3), which requires every company subject to examination to keep all books, records, accounts, papers, documents and any computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require in order that its representatives may readily verify the financial condition of the company, and ascertain whether the company has complied with the laws of this Commonwealth;

(v) Section 2141(b)(2) of Act 68 (40 P.S. § 991.2141), which requires the complaint process to consist of an initial review to include all of the following: (2) the allowance of a written or oral complaint;

(vi) Section 2166(A) of Act 68 (40 P.S. § 991.2166), which requires a licensed insurer or managed care plan to pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim;

(vii) Section 2166(B) of Act 68 (40 P.S. § 991.2166), which requires that if a licensed insurer or managed care plan fails to remit the payment as provided under subsection (A), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid;

(viii) Section 1 of the Insurance Company Law, Chapter 4, Article IV, No. 81 (40 P.S. § 771), requires all health insurance policies providing coverage on an expense incurred basis and service or indemnity type contracts issued by a nonprofit corporation subject to Chapter 61, Chapter 63 and Chapter 65, and all health services provided by plan operating under Act 364, the Voluntary Non Profit Health Service Act of 1972, also provide that the health insurance benefits or health services shall be payable with respect to a newborn child of the insured or subscriber from the moment of birth;

(ix) Section 617(A)(9) of the Insurance Company Law (40 P.S. § 752(a)(9)), which requires a policy delivered or issued for delivery after January 1, 1968 under which coverage of a dependent of a policyholder terminates at a specified age, shall, with respect to an unmarried child covered by the policy prior to the attainment of the age of 19 who is incapable of self-sustaining

employment by reason of mental retardation or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such policyholder for support and maintenance, not so terminate while the policy remains in effect and the dependent remains in such condition, if the policyholder has within 31 days of the dependent's attainment of the limiting age, submitted proof of such dependent's incapacity;

(x) Section 634 of the Insurance Company Law (40 P.S. §764e) , which requires:

(i) Any individual or group health insurance plan, sickness or accident insurance or subscriber contract or certificate issued by health insurers, health maintenance organization (HMO), or Blue Cross and Blue Shield plan, which provide hospital or medical/surgical coverage shall provide coverage of the equipment, supplies and out-patient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, and insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

(ii) Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin

infusion devices, pharmacological agents for controlling blood sugar and orthodics.

(iii) Diabetes outpatient self-management training and education;

(xi) Section 4 of the Pennsylvania Health Care Insurance Portability Act of June, 1997, P.L. 295, No. 29 (40 P.S. § 1302.4), which requires insurers comply with Section 2701(e)(1) of the Federal Act requiring a health insurer offering group health insurance coverage provide certification for a period of creditable coverage;

(xii) Act 191, Medical Foods Insurance Coverage Act (40 P.S. § 3901), which requires that any health insurance policy which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by any health care insurer shall provide that the health insurance benefits applicable under the policy include coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician;

(xiii) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), requires all applications for insurance and all claim forms contain or have attached thereto the following notice: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for

insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

(xiv) Title 31, Pennsylvania Code, Section 88.101, which requires application forms to contain a question to elicit information whether the insurance to be issued is to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used;

(xv) Title 31, Pennsylvania Code, Section 88.103, which states the notice required by § 88.102 of this title, relating to delivery to applicant, for an insurer other than a direct response insurer, shall provide a specified replacement notice;

(xvi) Title 31, Pennsylvania Code, Section 146.5, which requires every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time;

(xvii) Title 31, Pennsylvania Code, Section 146.6, which requires complete investigation of a claim within thirty days after notification of a claim. If such investigation cannot reasonably be completed within such time, provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected, within thirty days and every forty-five days thereafter; and

(xviii) Title 31, Pennsylvania Code, Section 154.18(c), which requires interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim.

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Deputy Insurance Commissioner makes the following Conclusions of Law:

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Respondent's violations of Sections 605, 606 and 623 of the Insurance Department Act (40 P.S. §§ 235, 236 and 253) are punishable by the following, under Section 639 of the Insurance Department Act (40 P.S. § 279):

(i) suspension, revocation or refusal to issue the certificate of qualification or license;

(ii) imposition of a civil penalty not to exceed five thousand dollars ($5,000.00) for every violation of the Act.

(iii) issue an order to cease and desist.

(iv) impose such other conditions as the department may deem appropriate.

(c) Respondent's violations of Sections 2141, 2166(A) and 2166(B) of Act 68 (40 P.S. §§ 991.2141 and 991.2166) are punishable under Section 2182 of Act 68, which states the Department may impose a penalty of up to five thousand dollars ($5,000.00) for a violation of this article.

(d) Respondent's violation of Sections 617 and 634 of The Insurance Company Law (40 P.S. §§ 752(a)(9) and 764e) is punishable by the following, under Section 655 of The Insurance Company Law (40 P.S. § 815), which states the Commissioner shall have the power to suspend or revoke the license of any insurance company which violates any of the provisions of subdivision (d) of this article.

(e) Respondent's violations of The Pennsylvania Health Care Insurance Portability Act, No. 29, (40 P.S. § 1302.4), are punishable under 40 P.S. § 1302.5:

(i) Upon satisfactory evidence of a violation of this act by any insurer or other person, the commissioner may pursue any one of the following courses of action:

1. Suspend, revoke or refuse to renew the license of the offending person.
2. Enter a cease and desist order.
3. Impose a civil penalty of not more than $5,000 for each action in violation of this act.
4. Impose a civil penalty of not more than $10,000 for each action in willful violation of this act.

(ii) Penalties imposed against a person under this act shall not exceed $500,000 in the aggregate during a single calendar year.

(f) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.5 and 146.6 are punishable under Section 9 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(g) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 - 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. § § 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

(i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00);

(ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Deputy Insurance Commissioner orders and Respondent consents to the following:

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.

(b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

(c) Respondent shall comply with all recommendations contained in the attached Report.

(d) Respondent shall pay Thirty Five Thousand Dollars ($35,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Harbert, Administrative Assistant, Bureau of Enforcement, 1311 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Deputy Insurance Commissioner finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein, may pursue any and all legal remedies available, including but not limited to the following: The Deputy Insurance Commissioner may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in

any other court of law or equity having jurisdiction; or the Deputy Insurance Commissioner may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Deputy Commissioner finds that there has been a breach of any of the provisions of this Order, the Deputy Commissioner may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Deputy Insurance Commissioner. Only the Insurance Commissioner or a duly authorized Deputy

Insurance Commissioner is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner.

BY: FORTIS INSURANCE COMPANY,
Respondent

~~President~~/Vice President Jennifer Kapps-Wagner

Secretary/~~Treasurer~~ Christina Palmer-Krizak
Sr. Vice President + General Counsel

RANDOLPH L. ROHRBAUGH
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination was conducted on Fortis Insurance Company, hereinafter referred to as "Company," at their Administrative Office located at 501 West Michigan Street, Milwaukee, Wisconsin, from November 12, 2002, through February 7, 2003. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in this Report may result in the imposition of penalties. Generally, practices, procedures, or files that were reviewed by the Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine potential impact upon Company operations or future compliance issues.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company personnel to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Company officers and employees during the course of the examination is hereby acknowledged.

The undersigned participated in this Examination and in preparation of this Report.

Chester A. Derk, Jr., AIE, HIA
Market Conduct Division Chief

Dan Stemcosky, AIE, FLMI
Market Conduct Division Chief

Lonnie L. Suggs
Market Conduct Examiner

Deborah Lee
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of July 1, 2001, through June 30, 2002, unless otherwise noted. The purpose of the examination was to determine the Company's compliance with Pennsylvania Insurance Laws and Regulations.

The examination focused on the Company's operation in areas such as: Advertising, Forms, Agent Licensing, Consumer Complaints, Underwriting Practices and Procedures and Claim Handling Practices and Procedures.

The Company was requested to identify the universe of files for each area of review during the experience period identified. Based on the universe sizes identified, a random sampling was utilized to select the files to be reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

Fortis Insurance Company, formerly known as Time Insurance Company, was incorporated in the State of Wisconsin on February 11, 1910. The Company received its certificate of authority to write business in the Commonwealth of Pennsylvania on October 31, 1961, and last renewed on April 1, 2004. The Company is authorized to do business in 47 states and the District of Columbia.

Fortis Insurance Company is a subsidiary of Interfinancial Inc. and operates as part of the Fortis Inc. group of life and health insurers, which is part of the Fortis International group. The ultimate parent companies are Fortis (B) of Belgium and Fortis (NL) of the Netherlands.

Fortis, Inc.'s U.S. operation has focused on employee benefit health care, group disability income, group dental, individual and small group major medical health insurance, individual life, pre-need funeral insurance, annuity and asset management markets. The Company sold their Medicare Supplement business in 1998 to United Teacher Associates, and their Long-Term Care business to John Hancock Financial Services in 2000.

Fortis Insurance Company conducts business through approximately 62,000 independent licensed representatives in 13,000 agencies under the supervision of regional sales directors and managing general agents. Additional health sales are made through alliances with a few large company agency forces, but account for a relatively modest percentage of new business written.

The Company's 2002 annual statement reflects direct Pennsylvania premiums for accident and health insurance to be $30,852.672 and life and annuity insurance direct premiums to be $3,047,212.

IV. ADVERTISING

Title 31, Pennsylvania Code, Section 51.2(c) provides that "Any advertisements, whether or not actually filed or required to be filed with the Department under the provisions of these Regulations, may be reviewed at any time at the discretion of the Department." The Department, in exercising its discretionary authority, requested the Company to provide copies of all advertising materials used for solicitation and sales during the experience period.

The Company identified and produced a total of 4 brochures for Individual Medical Products, 14 brochures for Small Group Products, and 2 newspaper advertisements for Special Products (Short Term Medical). The material consisted of prospecting enrollment brochures, invitation to enroll mailers, and additional coverage booklets and leaflets. All advertising including the Company's websites at www.temporaryinsurance.com, www.fortishealth.com, and www.fortis.com was reviewed to ascertain compliance with Act 205, Section 5 (40 P.S. §1171.5), Unfair Methods of Competition and Unfair or Deceptive Acts or Practices and Title 31, Pennsylvania Code, Chapter 51 and Chapter 89. No violations were noted.

V. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the administrative agreements, riders, amendments, endorsements, enrollment forms, application forms and policy forms used in order to verify compliance with requirements of the Accident and Health Filing Reform Act No. 159 (40 P.S. §3803), as well as provisions for various mandated benefits. Applications and claim forms were also reviewed to determine compliance with Title 18, Pa. C.S., Section 4117(k), Fraud Warning Notice. The following violations were noted:

351 Violations - Title 18, Pa. C. S., Section 4117(k)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties." A break down of the of 351 fraud statement violations are noted below.

2 Violations - The following 2 advertising forms did not contain the required fraud statement.

Area of Business	Form and Description	Comments
Individual Medical	Enrollment Form 26587	Incorrect Fraud Statement
Small Group	Stand alone Dental Form 28033	Incorrect Fraud Statement

11 Violations – The following 11 forms did not contain or have attached the required fraud statement.

Form and Description	Comments
Form 15036- Conversion Application Form	No Fraud Statement
Form 20716- Student Medical Plan Application	No Fraud Statement
Form 26587- Individual Medical Insurance Enrollment Form	Incorrect Fraud Statement
Form 518- Short Term Medical Certificate Application and Schedule	Incorrect Fraud Statement
Form 26419 –Group Employee Enrollment Form	No Fraud Statement
Form 26419 (Rev. 3/2001) –Group Employee Enrollment Form	No Fraud Statement
Form 27005 (Rev. 2/2001) – Enrollment Form	Incorrect Fraud Statement
Form 27849 Individual Application	No Fraud Statement
Form 27922 Individual Application	No Fraud Statement
Form 27926 Individual Application	No Fraud Statement
Form Express Script Claim Form	No Fraud Statement

202 Violations - The following forms, utilized in the enrollment of 202 individuals for group coverage, did not contain the required fraud statement.

Form	Description	Comments
Form 26419	Pennsylvania Group Insurance Employee Enrollment Form Groups of 2-50	No Fraud Statement
Form 26419 (Rev. 3/2001)	Pennsylvania Group Insurance Employee Enrollment Form	No Fraud Statement

2 Violations - The form utilized in 2 enrollments identified in the declined certificate files did not contain the required fraud statement.

Form	Description	Comments
Form 27005 (Rev. 2/2001)	Enrollment Form	Incorrect Fraud Statement

48 Violations – The following forms utilized in the 48 applications for individual medical policies did not contain or have attached thereto the required fraud notice.

Form	Description	Comments
"Application for Student Select Plan:	Application	No Fraud Statement
"Student Select Application"	Application	No Fraud Statement

70 Violations - The applications utilized in the 70 individual declined policy files reviewed, did not contain or have attached thereto the required fraud notice

Form	Description	Comments
Forms - 26587, 27849, 27922 and 27926	Application	No Fraud Statement

1 Violation – The following claim form identified in the claim files review did not contain or have attached thereto the required fraud statement.

Form	Description	Comments
"TIME" 15687 (Rev. 4-88)	Claim Form	No Fraud Statement

15 Violations - The following claim forms, identified in 15 prescription claim files, did not contain or have attached thereto the required fraud statement.

Form	Description	
21055 (Rev. 1/2001)	Express Script Inc. Claim Form	No Fraud Statement
21055 (Rev. 8-97)	Express Script Inc. Claim Form	No Fraud Statement

2 Violations – Medical Foods Insurance Coverage Act, No. 191 (40 P.S. §3901)

Any health insurance policy which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by any health care insurer shall provide that the health insurance benefits applicable under the policy include coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician. The following forms did not contain required provisions for medical foods coverage.

Form Name	Form Number
Certificate of Group Medical Coverage	C94.100.SIG.PA
Medical Certificate Master Group Policies	Form 225

2 Violations –Insurance Company Law, Chapter 2, Section 617(A)(9), (40 P.S. §752(a)(9)) Physically Handicapped/Mentally Retarded Child

A policy delivered or issued for delivery after January 1, 1968 under which coverage of a dependent of a policyholder terminates at a specified age, shall, with respect to an unmarried child covered by the policy prior to the attainment of the age of nineteen who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapable prior to attainment of age nineteen and who is chiefly dependent upon such policyholder for support and maintenance, not so terminate while the policy remains in effect and the dependent remains in such condition , if the policyholder has within thirty-one days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The following contract forms did not contain provisions for the required mandated coverage.

Form Name	Form Number
Certificate of Group Medical Coverage	C94.100.SIG.PA
Student Major Medical Policy	Form 553-PA

1 Violation - Insurance Company Law, No. 284, Section 634 (40 P.S. §764e), Reimbursement for Diabetic Supplies.

(a) Any individual or group health insurance plan, sickness or accident insurance or subscriber contract or certificate issued by health insurers, health maintenance organization (HMO), or Blue Cross and Blue Shield plan, which provide hospital or medical/surgical coverage shall provide coverage of the equipment, supplies and out-patient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, and insulin-using diabetes , gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally

authorized to prescribe such items under law.

(c) Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

(d) Diabetes outpatient self-management training and education.

The following contract did not contain a provision for mandated diabetic coverage.

Form Name	Form Number
Student Major Medical Policy	Form 553-PA

1 Violation – Insurance Company Law, Chapter 4, Article IV, No. 81 (40 P.S. §771) Health Insurance Coverage for New Born Children

All health insurance policies providing coverage on an expense incurred basis and service or indemnity type contracts issued by a nonprofit corporation subject to 40 Pa. C. S., Chapter 61 (relating to Hospital Plan Corporations), Chapter 63 (relating to Professional Health Services Plan Corporations), Chapter 65 (relating to Fraternal Benefit Societies), and all health services provided by plans operating under the act of December 29, 1972 (P.L. 1701, No. 364) known as the "Voluntary Non profit Health Service Act of 1972," also provide that the health insurance benefits or health services applicable shall be payable with respect to a newborn

child of the insured or subscriber the moment of birth. The following certificate of coverage did not contain the provision for New Born Children coverage.

Form Name	**Form Number**
Short Term Medical Certificate Application and Schedule	Form 518

VI. AGENT LICENSING

The Company was requested to provide a list of all agents active and terminated during the experience period. Section 606 (40 P.S. §236) of the Insurance Department Act requires all entities to report all appointments and terminations to the Insurance Department. Section 605 (40 P.S. §235) of the Insurance Department Act prohibits agents from doing business on behalf of any entity without a written appointment from that entity. Section 623 (40 P.S. §253) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. The Company identified 2,454 licensed agents during the period. All 2,454 agents and agents identified in the underwriting files during the examination were compared to the Insurance Department licensing records to verify compliance with Section 605, Section 606 and Section 623 of the Insurance Department Act. The following violations were noted:

1 Violation - Insurance Department Act, Section 606 (40 P.S. §236)
All entities shall report to the Insurance Department all appointments and terminations of appointments in the format and time frame required by the Insurance Department's regulations. The Company failed to report all agent appointments and terminations to the Insurance Department.

62 Violations - Insurance Department Act, Section 605 (40 P.S. §235) Appointment.

(a) No agent shall do business on behalf of any entity without a written appointment from that entity.

(b) All appointments shall be obtained by procedures established by the Insurance Department's regulations.

(c) Insurance entities authorized to do business in this Commonwealth shall, from time to time as determined by the Insurance Department, certify to the Insurance Department the names of all agents appointed by them.

(d) Each appointment fee, both new and renewal, shall be paid in full by the entity appointing the agent.

The Company failed to certify and submit appointment fees to the Insurance Department for the following 62 agents who were identified as soliciting business in Pennsylvania.

	Last Name	First Name
1	Allen	Stuart
2	Antonneau	Heather
3	Bachman	Walter
4	Bailey	Richard
5	Baker	Donald
6	Batts	Hundley
7	Berman	David
8	Boley	Todd
9	Brewster	Lyle
10	Buecker	Allan
11	Bulinski	Martin
12	Delana	Jared
13	Dierker	Richard
14	Divito	John
15	Downing	Gary
16	Duet, Jr.	Stephen
17	Etheredge	David
18	Fantanaros	Nick
19	Galaska	Philip
20	Garner	William
21	Gaworski	Terrence
22	Glick	Sally
23	Gooder	Stephen
24	Hallum	Alvin
25	Harkins	Terese
26	Harr, Jr.	William
27	Hill	Dan

28	Hogan	Brad
29	Hopkins	Michael
30	Hopkins, Jr.	Jack
31	Karpe	Eileen
32	Kauffman	Douglas
33	Kidd	John
34	King	Keith
35	Knopf	Whitney
36	Light	Steven
37	Linnert	David
38	Lodge	Lynn
39	Lynn	John
40	Maercklein	Thomas
41	Mann-O'neill	Marcia
42	Marder	Barry
43	Marotz	Adam
44	Maslow	Arnold
45	Mielke	Craig
46	Nation	Jody
47	Pearce	Carolyn
48	Rathert	Kevin
49	Riggio	Patricia
50	Russell	Charles
51	Smith	Kim
52	Summers	S
53	Thompson	Robert
54	Turcios	Colleen
55	USBA Service	
56	Wallach	Richard
57	Walro	Gary
58	Webb	Robert
59	Wholehan	Michael
60	Wood	James
61	Wright	Jonathan
62	Zastudil	Thomas

55 Violations – Insurance Department Act, Section 623 (40 P.S. §253)

Any entity or the appointed agent of any entity accepting applications or orders for insurance or securing any insurance business through anyone acting without a license commits a misdemeanor of the third degree. The following 55 individuals were identified, either soliciting applications or orders for insurance, or securing

insurance business for the Company. Department records do not identify them as holding a Pennsylvania insurance license.

	Last Name	First Name
1	Allen	Stuart
2	Antonneau	Heather
3	Bailey	Richard
4	Baker	Donald
5	Batts	Hundley
6	Berman	David
7	Boley	Todd
8	Brewster	Lyle
9	Buecker	Allan
10	Bulinski	Martin
11	Bush	Ronny
12	Chambers	Lloyd
13	Chiesa	Robert
14	Coleman	William
15	Delana	Jared
16	Dierker	Richard
17	Divito	John
18	Downing	Gary
19	Duet, Jr.	Stephen
20	Etheredge	David
21	Galaska	Philip
22	Garner	William
23	Glick	Sally
24	Hallum	Alvin
25	Harr, Jr.	William
26	Hill	Dan
27	Hogan	Brad
28	Hopkins	Michael
29	Hopkins, Jr.	Jack
30	Kidd	John
31	King	Keith
32	Knopf	Whitney
33	Light	Steven
34	Linnert	David
35	Lynn	John
36	Maercklein	Thomas
37	Mann-O'neill	Marcia
38	Marotz	Adam
39	Maslow	Arnold

40	Mielke	Craig
41	Nation	Jody
42	Pearce	Carolyn
43	Phlamm	James
44	Rathert	Kevin
45	Russell	Charles
46	Smith	Kim
47	Summers	S
48	Turcios	Colleen
49	USBA Service	
50	Wallach	Richard
51	Walro	Gary
52	Webb	Robert
53	Wholehan	Michael
54	Wood	James
55	Zastudil	Thomas

VII. CONSUMER COMPLAINTS

The Company was requested to provide a listing of all complaints received during the experience period. The Company identified 402 internal consumer complaints received and an additional 28 complaints were forwarded to the Company from the Department of Insurance during the experience period. A sample of 50 internal complaints, all 28 Department of Insurance complaints and copies of Pennsylvania complaint logs for calendar years 1999, 2000, 2001 and 2002 were requested, received and reviewed.

The primary purpose of the review was to verify compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S.§1171). Section 5(a)(11) of the Act requires a Company to maintain a complete record of all complaints received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. The following violations were noted:

1 Violation - Health Care Accountability and Protection Act, No. 68, Section 2141(b)(2), (40 P.S. §991.2141)

The complaint process shall consist of an initial review to include all of the following:

(2) The allowance of a written or oral complaint.

The denial letter sent to a member on August 3, 2001, incorrectly stated the member would have 60 days from the date of the letter to submit a written grievance for review. A complaint need not be in writing.

12 Violations – Title 31, Pennsylvania Code, Section 146.5 Failure To Acknowledge Pertinent Communication

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communication from a claimant, which reasonably suggest that a response is expected.

The Company failed to respond within the required time frame in 12 claim related complaint files.

VIII. UNDERWRITING

The Underwriting review was sorted and conducted in 8 general segments.

A. Underwriting Guidelines
B. Group Policies Issued
C. Group Policies Declined and Terminated
D. Certificateholders Declined
E. Individual Medical Policies Issued
F. Individual Policies Terminated
G. Individual Applications Declined
H. Conversion Policies

Each segment was reviewed for compliance with underwriting practices and verification of premium rates, forms identification and agent identification. Issues relating to forms and agent licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

A. Underwriting Guidelines

The Company was requested to provide copies of all established written underwriting guidelines, manuals, bulletins, directives, management correspondence and rating methodology in use during the experience period. The Company provided their underwriting manual titled "Small Group and Individual Medical Underwriting Guidelines". The underwriting manual was reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place which could possibly be considered discriminatory in nature or specifically prohibited by statute or regulation. No violations were noted.

B. Group Policies Issued

The Company was requested to provide a listing of all group policies issued during the experience period. The Company reported a total of 179 group accounts issued. A random sample of 25 new group accounts was requested for review. Of the 25 files requested, 24 files were received and reviewed. The files were reviewed to verify underwriting and forms compliance as required by the Accident and Health Filing Reform Act, No.159 (40 P.S.§3803) Section 3(e)(5) and Health Insurance Portability and Accountability Act, Title XXVII, Section 2791(d)(6), as adopted by the Pennsylvania Health Care Insurance Portability Act, No. 29, which states a group shall include only employers of two or more employees. The following violation was noted:

1 Violation – Insurance Department Act, Section 903 (40 P.S. §323.3)
Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any of all computer or other recordings relating to its property, assets, business and affairs in such

manner and for such time periods as the Department, at its discretion, may require in order that its authorized representatives may ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to provide one group account file for review.

C. Group Policies Declined and Terminated

The Company identified 32 commercial groups declined coverage and 111 group policies terminated during the experience period. All 32 declined groups and a sample selection of 25 terminated groups were selected, received and reviewed. The group files were reviewed to verify compliance with the Health Insurance Portability and Accountability Act, Title XXVII, Sec. 2701 (e)(1)(A)(i), as adopted by the Pennsylvania Health Care Insurance Portability Act, No.29 (40 §1302.4). This Section of the Act requires a group health plan, and a health insurer offering group health insurance coverage, to provide certificates of creditable coverage. The following violations were noted:

85 Violations - Health Insurance Portability and Accountability Act, Title XXVII, Section 7201(e), Adopted by the Pennsylvania Health Care Insurance Portability Act, No. 29 (40 P.S. §1302.4)

Requirement for certification of period of creditable coverage. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide the certification.

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision.

The Company failed to provide evidence of the issuance of Certificates of Creditable Coverage to 85 terminated members.

D. Certificateholders Declined Coverage

The Company identified a universe of 199 certificateholders declined coverage during the experience period. A random sample of 50 declined files was requested for review. Of the 50 files requested, 49 were received and reviewed. The files were reviewed to determine compliance with Title 31, Pennsylvania Code, Chapter 88, Title 18 Pa. C.S., Section 4117(k), and the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). The following violation was noted:

1 Violation – Insurance Department Act, Section 903 (40 P.S. §323.3)
Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the Company or person has complied with the laws of this Commonwealth. The Company failed to provide the file noted.

E. Individual Medical Policies Issued

The Company identified a total of 2,042 individual medical policies and 301 Student Major Medical policies issued during the experience period. A random sample of 50 files was selected for review. Of the 50 files requested, 48 files were received and reviewed. The files were reviewed to ensure compliance with Title 31, Pennsylvania Code, Chapter 88; Title 18 Pa. C.S., Section 4117(k); and the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). The following violations were noted:

2 Violations – Insurance Department Act, Section 903 (40 P.S. §323.3)

Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the Company or person has complied with the laws of this Commonwealth. The Company failed to provide applications for the 2 files noted.

48 Violations - Title 31, Pennsylvania Code, Section 88.101

Application forms shall contain a question to elicit information as to whether the insurance to be issued is to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used. The applications in the 48 files noted did not include a replacement question.

F. Individual Accident and Health Policies Terminated

The Company identified a total of 2,462 Individual Accident and Health policies terminated during experience period. A random sample of 75 files was selected, received, and reviewed. The files were reviewed to ensure that terminations were not the result of any discriminatory underwriting practice. No violations were noted.

The following is a brief synopsis of the 75 terminated policies.

Number	Termination Reason	Percent
43	Policyholders Request	57%
29	Non-Payment/Lapse	39%
3	Termed/Re-Instated	4%
75	Totals	100%

G. Individual Policies Declined

The Company identified a total of 674 policies declined during the experience period. A random sample of 75 declined policies was selected, received and reviewed. The files were reviewed to ensure compliance with Title 18, Pa. C.S., Section 4117(k), the Unfair Insurance Practices Act, No. 205, (40 P.S. §1171) and to ensure declinations were not the result of any discriminatory underwriting practice. The following violations were noted:

3 Violations – Insurance Department Act, Section 903 (40 P.S. §323.3)

Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the Company or person has complied with the laws of this Commonwealth. The applications in the 3 files noted were illegible.

36 Violations – Title 31, Pennsylvania Code, Section 88.103

The notice required by §88.102 of this title (relating to delivery to applicant) for an insurer other than a direct response insurer, shall provide a specified replacement notice. Of the 75 declined applications reviewed, 36 applicants indicated on the replacement question in the application that the proposed new coverage would be replacing or changing an existing health insurance plan, but the files noted did not indicate the required replacement notice was provided.

H. Conversion Policies

The Company identified 23 conversion policies in-force during the experience period. All 23 conversion files were selected, received and reviewed. A conversion policy is a policy issued to an individual who contractually changed their group coverage to individual coverage. The files were reviewed to ensure compliance with issuance, underwriting, and rating statutes and regulations. Further review was conducted to verify compliance with Pennsylvania Health Care Insurance Portability Act, No. 29, Section 4 (40 P.S. §1302.4), requirements for certification of period of creditable coverage. No violations were noted.

IX. INTERNAL AUDIT AND COMPLIANCE PROCEDURES

The Company was requested to provide copies of their internal audit and compliance procedures. The audits and procedures were reviewed to ensure compliance with Insurance Company Law, Section 405-A (40 P.S. §625-5). Section 405-A provides for the establishment and maintenance of internal audit and compliance procedures, which provides for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising, and filing and approval requirements for life insurance and annuities. The procedures shall also provide for the following:

(1) Periodic reviews of consumer complaints in order to determine patterns of improper practices.

(2) Regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.

(3) The establishment of lines of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company employees whose compensation, other than generally applicable company bonus or incentive plans, is not directly linked to marketing or sales.

No violations were noted.

X. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided the following 3 manuals: A claim processing manual(ACES), a manual of charts (ACES FLIPCHART), and an adjustments manual. The manuals were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The Claim file review consisted of six areas:

A. Prompt Payment of Provider Claims
B. Individual Health Medical Claims
C. Individual Student Health Plan Claims
D. Individual Medical Claims
E. Short Term Medical Claims
F. Prescription Drug Claims

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). The provider-submitted claim files were reviewed for compliance with Act 68, Section 2166, (40 P.S. §991.2166) Prompt Payment of Claims, and the insured-submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Claim Settlement Practices.

A. Prompt Payment of Provider Claims

The Company identified a universe of 534 provider submitted clean claims paid over 45 days from receipt. The 534 claims consisted of 402 Individual Medical claims, 77 Small Group claims, and 55 Short-Term Medical claims. A combined sample of 86 clean provider submitted claim files was selected, received, and reviewed to validate the accuracy of the report data provided by Company and determine compliance with Act 68, Section 2166, (40 P.S. §991.2166) Prompt Payment of Claims. A clean claim, by definition, is a claim for payment for a health care service, which has or no defect or impropriety. The following violations were noted:

534 Violations - Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims
(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. A total of 534 provider submitted clean claims were not paid within the required 45 day time period.

1 Violation - Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims
(B) If a licensed insurer or a Managed Care Plan fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars. The Company failed to pay the required interest on the claim noted.

1 Violation – Title 31, Pennsylvania Code, Section 154.18(c)

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim. The Company failed to pay the required interest within 30 days for the file noted.

B. Individual Health Medical Claims

The Company identified a total universe of 63,570 Individual Health Medical claims processed during the experience period. A random sampling of 50 Individual Health Medical claim files was requested, received and reviewed. The following violations were noted:

1 Violation – Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. The Company failed to acknowledge receipt of the claim within 10 working days in the file noted.

C. Individual Student Health Plan Claims

The Company identified a universe of 742 Student Health Plan claims submitted during the experience period. A random sampling of 25 Student Health Plan claim files was requested, received and reviewed. No violations were noted.

D. Individual Medical Claims

The Company identified a total universe of 7,702 Individual Medical claims submitted during the experience period. A random sampling of 25 Individual Medical claim files was requested, received and reviewed. No violations were noted.

E. Short Term Medical Claims

The Company identified a total universe of 4,095 Short-Term Medical claims submitted during the experience period. A random sampling of 25 Short-Term Medical claim files was requested, received and reviewed. The following violations were noted:

1 Violation – Title 31, Pennsylvania Code, Section 146.5
Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. The Company failed to acknowledge receipt of the claim within 10 working days in the file noted.

1 Violation - Title 31, Pennsylvania Code, Section 146.6
Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide status letters in the file noted.

F. Prescription Drug Claims

The Company was requested to identify and provide a listing of all prescription drug claims submitted directly by members. The Company received a total of 140 prescription drug claims during the experience period. Express Scripts Inc. is the third-party administrator for prescription drug coverage. A sample of 25 prescription drug claims was selected, received and reviewed. The following violations were noted:

18 Violations – Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. The Company failed to acknowledge receipt of the claim within 10 working days in the 18 files noted.

2 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide status letters in the 2 files noted.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must implement procedures to ensure compliance with requirements of Quality Health Care Accountability and Protection Act, No. 68, Section 2166, (40 P.S. § 991.2166), Prompt Payment of Provider Claims.

2. The Company must implement procedures to ensure compliance with the requirements of Title 18, Pa. C. S., §4117(k) whereby all applications for insurance and all claim forms shall contain or have attached thereto the required fraud notice.

3. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

4. The Company must review and revise Licensing procedures to ensure compliance with Insurance Department Act, Sections 605, Section 606 and Section 623 (40 P.S. §§235, 236 and 253).

5. The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations.

   A. Medical Foods Insurance Coverage Act, No. 191 (40 P.S. §3901).
   B. Insurance Company Law, No. 284, Section 634 (40 P.S. §764e), Reimbursement for Diabetic Supplies.
   C. Insurance Company Law, Section 617(A)(9) (40 P.S. §752(a)(9)) Physically Handicapped/Mentally Retarded Child
   D. Insurance Company Law, Chapter 4, Section 1 (40 P.S. §771) New Born Children Coverage.

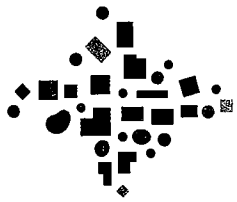
6. The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a), (40 P.S. §323.3) of the Insurance Department Act.

7. The Company must review internal control procedures to ensure compliance with replacement requirements of Title 31, Pennsylvania Code, Chapter 88.

8. The Company must review and revise internal control procedures to ensure compliance with the issuance of the certificates of creditable coverage requirements of the Pennsylvania Health Care Insurance Portability Act, No. 29 (40 P.S. §1302.4).

XII. COMPANY RESPONSE

June 23, 2004



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Mr. Daniel A. Stemcosky
Market Conduct Division Chief
Commonwealth of Pennsylvania
Insurance Department
Bureau of Enforcement
1321 Strawberry Square
Harrisburg, PA 17120

Re: Market Conduct Examination of Fortis Insurance Company, NAIC #69477
Exam Period: 7/1/01 – 6/30/02
Examination Warrant Number: 02-M11-020

Fortis Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI
53201-3050
Telephone
1 800 800 1212

Dear Mr. Stemcosky:

Thank you for the opportunity to respond to the Department's Report of Examination of Fortis Insurance Company covering the period of time from July 1, 2001 through June 30, 2002. The following is our response to the Department's findings and recommendations:

1. **Forms – pages 6-8:**

Violations: 351 applications and/or claim forms did not have the required fraud notice.

Title 18, Pa. C. S., Section 4117(k)
All applications for insurance and all claim forms shall contain or have attached thereto the following notice: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

Recommendation: The Company must implement procedures to ensure compliance with the requirements of Title 18, Pa. C. S., §4117(k) whereby all applications for insurance and all claim forms shall contain or have attached thereto the required fraud notice.

Response: We note no areas of disagreement. We are in the process of implementing the requirements of Title 18, Pa. C. S., §4117(k) whereby all applications for insurance and all claim forms will contain or have attached thereto the required fraud notice.

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2. **Forms – page 9:**

Violations: 2 forms did not include provisions for the required mandated coverage, Reimbursement for Cancer Therapy.

Insurance Company Law, Chapter 2, Section 631 (40 P.S. §764b) Reimbursement for Cancer Therapy. (a)Whenever any individual or group health, sickness or accident insurance policy or subscriber contract or certificate issued by any entity subject to 40 Pa. C.S. Chs.61 (relating to hospital plan corporations) and 63 (relating to professional health services plan corporations), this act, or the act of July 29, 1977 (P.L. 105, No. 38), known as the "Fraternal Benefit Society Code," providing hospital or edical/surgical coverage includes within their coverage benefits for cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer, the covered individual shall be entitled to benefits for cancer chemotherapy and cancer hormone treatments, whether performed in a physician's office, in an outpatient department of a hospital, in a hospital as a hospital inpatient or in any other medically appropriate treatment setting. The following contract forms did not contain provisions for the required mandated coverage.

Form Name	Form Number
Certificate of Group Medical Coverage	C94.100.SIG.PA
Medical Certificate Master Group Policies	Form 225

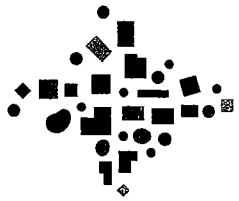
Recommendation: The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations: Insurance Company Law, Section 631 (40 P.S. §764b) Reimbursement for Cancer Therapy.

Response: Based on our review of § 40-39-123 (Parallel Citations 40 P.S. §764b), we disagree with the conclusion that this benefit must be included in the certificate of insurance. The law requires coverage of FDA approved cancer chemotherapy and cancer hormone treatments and services in any setting *if* the underlying policy or certificate of insurance provides benefits for this type of coverage. It is our position that the law does not mandate coverage of the benefit, but rather prohibits discrimination in the payment of benefits on the basis of the setting in which the services or treatment is provided. Therefore, we respectfully note no violation of Pennsylvania law.

3. **Forms – page 9-10:**

Violations: 3 forms did not include provisions for the required mandated coverage, medical foods.

Medical Foods Insurance Coverage Act, No. 191 (40 P.S. §3901)
Any health insurance policy which is delivered, issued for delivery, renewed, extended or modified in this Commonwealth by any health care insurer shall provide that the health insurance benefits applicable under the policy include coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician.



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The following forms did not contain required provisions for medical foods coverage.

Form Name	Form Number
Certificate of Group Medical Coverage	C94.100.SIG.PA
Student Major Medical Policy	Form 553-PA
Medical Certificate Master Group Policies	Form 225

Recommendation: The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations: Medical Foods Insurance Coverage Act, No. 191 (40 P.S. §3901)

Response for Form Number C94.100.SIG.PA: Based on our review of § 40-39-343 (Parallel Citation 40 P.S. §309), we disagree that this benefit must be included in this certificate of insurance. The law applies to group and individual health insurance policies and does not extend to certificates of insurance. Please note that the C94.100.SIG.PA is a certificate of insurance that is issued pursuant to a master policy that is issued in the state of Alabama. Therefore, we respectfully note no violation of Pennsylvania law.

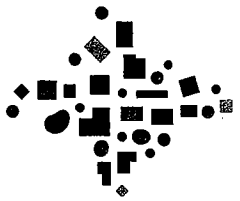
Response for Form Number 553-PA: Based on our review of § 40-39-343, we disagree that this benefit must be included in this policy. The term "health insurance policy" as defined in § 40-39-343 only applies to plans that provide coverage for prescription drugs. Please note that prescription drug coverage is not a benefit provided in Form 553-PA. Therefore, we respectfully note no violation of Pennsylvania law.

Response for Form 225: Based on our review of § 40-39-343 (Parallel Citation 40 P.S. §309), we disagree that this benefit must be included in this certificate of insurance. The law applies to group and individual health insurance policies and does not extend to certificates of insurance. Please note that the Form 225 is a certificate of insurance that is issued pursuant to a master policy that is issued in the state of Illinois. Therefore, we respectfully note no violation of Pennsylvania law.

4. **Forms – page 10:**

Violations: 2 forms did not include provisions for the required coverage, Physically Handicapped/Mentally Retarded Child.

Insurance Company Law, Chapter 2, Section 617(A)(9), (40 P.S. §752(a)(9)) Physically Handicapped/Mentally Retarded Child. A policy delivered or issued for delivery after January 1, 1968 under which coverage of a dependent of a policyholder terminates at a specified age, shall, with respect to an unmarried child covered by the policy prior to the attainment of the age of nineteen who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapable prior to attainment of age nineteen and who is chiefly dependent upon such



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policyholder for support and maintenance, not so terminate while the policy remains in effect and the dependent remains in such condition , if the policyholder has within thirty-one days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The following contract forms did not contain provisions for the required mandated coverage.

Form Name	Form Number
Certificate of Group Medical Coverage	C94.100.SIG.PA
Student Major Medical Policy	Form 553-PA

Recommendation: The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations: Insurance Company Law, Section 617(A)(9) (40 P.S. §752(a)(9)) Physically Handicapped/Mentally Retarded Child.

Response for Form Number C94.100.SIG.PA: Based on our review of § 40-39-102, (Parallel Citation 40 P.S. §752), we disagree that this benefit must be included in this certificate of insurance. The law applies to policies and does not extend to certificates of insurance. Please note that the C94.100.SIG.PA is a certificate of insurance that is issued pursuant to a master policy that is issued in the state of Alabama. Therefore, we respectfully note no violation of Pennsylvania law.

Response for Form 553-PA: While we acknowledge that the Form 553-PA does not specifically address coverage for physically handicapped and mental retarded dependents as outlined in § 40-39-102(A)(9) (Parallel Citations 40 P.S. §752), we disagree that the policy is deficient. There is a *Conformity with State Statutes* provision on page 19 of the policy that provides: "If this Policy on its effective date, is in conflict with the State laws where You live, it is changed to meet the minimum requirements of those laws." It is our position that this provision extends coverage for applicable state benefit mandates that may not be specifically addressed in the certificate of insurance.

Please be advised that we administratively allow coverage to continue for covered dependents if they meet the criterion in the statute.

5. **Forms – pages 10-11:**

Violation: 1 form did not include provisions for the required coverage, Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.

Insurance Company Law, Section 602-A (40 P.S. §908-2) Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options. (a) All group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act, to 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations), the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act" or the act of July 29, 1977 (P. L. 105, No. 38), known as the " Fraternal Benefit Society Code," providing hospital or medical/surgical coverage, shall in addition to other provisions required by this act

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include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in sections 603-A, 604-A, and 605-A.

The following contract did not contain provisions for the required mandated coverage:

Form Name	Form Number
Student Major Medical Policy	Form 553-PA

Recommendation: The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations: Insurance Company Law, Section 602-A (40 P.S. §908-2) Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.

Response: Based on our review of § 40-62-102 (Parallel Citation 40 P.S. §908-2), we disagree that this benefit must be included in this policy because the law only applies to group policies. Please note that Form 553-PA is an individual major medical policy that is sold and marketed to students and it would not be regulated as group health insurance. Therefore, we respectfully note no violation of Pennsylvania law.

6. **Forms – page 11:**

Violation: 1 form did not contain a conversion provision.

Insurance Company Law, Section 621.2(d) (40 P.S. §981-9) A group policy delivered or issued in this State which provide hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, but not a policy which provides indemnity benefits or benefits for specific diseases or for accidental injuries only, shall provide that an employe or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and under any group policy providing similar benefits which its replaces) for at least three months immediately prior to termination, shall be entitled to have issued to him by an insurer a policy of health insurance.

The following contract did not contain a provision for conversion.

Form Name	Form Number
Student Major Medical Policy	Form 553-PA

Recommendation: The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations: Insurance Company Law, Section 621.1(d), (40 P.S. §981-9) Conversion Coverage.

Response: Based on our review of § 40-39-110 (Parallel Citation 40 P.S. §756.2), we disagree that this benefit must be included in this policy because the law only applies to group policies. Please note that Form 553-PA is an individual major medical policy that is sold and marketed to students and it would not be regulated as group health insurance. Therefore, we respectfully note no violation of Pennsylvania law.

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7. **Forms – pages 11-12:**

Violation: 1 form did not include provisions for the required coverage, Reimbursement for Diabetic Supplies.

Insurance Company Law, No. 284, Section 634 (40 P.S. §764e), Reimbursement for Diabetic Supplies. (a) Any individual or group health insurance plan, sickness or accident insurance or subscriber contract or certificate issued by health insurers, health maintenance organization (HMO), or Blue Cross and Blue Shield plan, which provide hospital or medical/surgical coverage shall provide coverage of the equipment, supplies and out-patient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, and insulin-using diabetes , gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. (c) Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics. (d) Diabetes outpatient self-management training and education.

The following contract did not contain a provision for mandated diabetic coverage.

Form Name	Form Number
Student Major Medical Policy	Form 553-PA

Recommendation: The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations: Insurance Company Law, No. 284, Section 634 (40 P.S. §764e), Reimbursement for Diabetic Supplies.

Response: While we acknowledge that Form 553-PA does not specifically address coverage for diabetic supplies as outlined in § 40-39-126 (Parallel Citations 40 P.S. §764e), we disagree that the policy is deficient. There is a *Conformity with State Statutes* provision on page 19 of the policy that provides: "If this Policy on its effective date, is in conflict with the State laws where You live, it is changed to meet the minimum requirements of those laws." It is our position that this provision extends coverage for applicable state benefit mandates that may not be specifically addressed in the certificate of insurance. Please be advised that we allow coverage for reimbursement for diabetic supplies as long as it meets the criterion in the statute.

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8. **Forms – page 12:**

Violation: 1 form did not include provisions for the required coverage, Health Insurance Coverage for New Born Children.

Insurance Company Law, Chapter 4, Article IV, No. 81 (40 P.S. §771) Health Insurance Coverage for New Born Children. All health insurance policies providing coverage on an expense incurred basis and service or indemnity type contracts issued by a nonprofit corporation subject to 40 Pa. C. S., Chapter 61 (relating to Hospital Plan Corporations), Chapter 63 (relating to Professional Health Services Plan Corporations), Chapter 65 (relating to Fraternal Benefit Societies), and all health services provided by plans operating under the act of December 29, 1972 (P.L. 1701, No. 364) known as the "Voluntary Non profit Health Service Act of 1972," also provide that the health insurance benefits or health services applicable shall be payable with respect to a newborn child of the insured or subscriber the moment of birth. The following certificate of coverage did not contain the provision for New Born Children coverage.

Form Name	Form Number
Short Term Medical Certificate Application and Schedule	Form 518

Recommendation: The Company must review and implement procedures to ensure all required mandated benefits are included in applicable certificates of coverage and policy contracts as provided by the following laws and regulations: Insurance Company Law, Chapter 4, Section 1 (40 P.S. §771) New Born Children Coverage.

Response: Based on our review of § 40-39-301(Parallel Citation 40 P.S. § 771), we disagree that this benefit must be included in this short-term certificate of insurance. The law applies to policies and does not extend to certificates of insurance. Please note that the Form 518 is a certificate of insurance that is issued pursuant to a master policy that is issued in the state of Alabama. Therefore, we respectfully note no violation of Pennsylvania law.

9. **Agent Licensing – page 13:**

Violations: 1 for failure to report all agent appointments and terminations to the Insurance Department

Insurance Department Act, Section 606 (40 P.S. §236)
All entities shall report to the Insurance Department all appointments and terminations of appointments in the format and time frame required by the Insurance Department's regulations. The Company failed to report all agent appointments and terminations to the Insurance Department.

Recommendation: The Company must review and revise Licensing procedures to ensure compliance with Insurance Department Act, Sections 605, Section 606 and Section 623 (40 P.S. §§235, 236 and 253).

Response: We note no areas of disagreement. We will reinforce the requirements of Section 606 (40 P.S. §236) with our Agent Licensing Department.

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10. **Agent Licensing – pages 13-15:**

Violations: 62 for failure to certify and submit agent appointment fees to the Insurance Department.

Insurance Department Act, Section 605 (40 P.S. §235) Appointment.
(a) No agent shall do business on behalf of any entity without a written appointment from that entity.
(b) All appointments shall be obtained by procedures established by the Insurance Department's regulations.
(c) Insurance entities authorized to do business in this Commonwealth shall, from time to time as determined by the Insurance Department, certify to the Insurance Department the names of all agents appointed by them.
(d) Each appointment fee, both new and renewal, shall be paid in full by the entity appointing the agent.
The Company failed to certify and submit appointment fees to the Insurance Department for 62 agents who were identified as soliciting business in Pennsylvania.

Recommendation: The Company must review and revise Licensing procedures to ensure compliance with Insurance Department Act, Sections 605, Section 606 and Section 623 (40 P.S. §§235, 236 and 253).

Response: We note no areas of disagreement. We will reinforce the requirements of Sections 605, Section 606 and Section 623 (40 P.S. §§235, 236 and 253) with our Agent Licensing Department.

11. **Agent Licensing – pages 15-17:**

Violations: 55 agents were identified as not holding a Pennsylvania license.

Insurance Department Act, Section 623 (40 P.S. §253)
Any entity or the appointed agent of any entity accepting applications or orders for insurance or securing any insurance business through anyone acting without a license commits a misdemeanor of the third degree. 59 individuals were identified, either soliciting applications or orders for insurance, or securing insurance business for the Company. Department records do not identify them as holding a Pennsylvania insurance license.

Recommendation: The Company must review and revise Licensing procedures to ensure compliance with Insurance Department Act, Sections 605, Section 606 and Section 623 (40 P.S. §§235, 236 and 253).

Response: We note no areas of disagreement. We will reinforce the requirements of Sections 605, Section 606 and Section 623 (40 P.S. §§235, 236 and 253) with our Agent Licensing Department.

12. **Consumer Complaints – page 18:**

Violation: 1 - Health Care Accountability and Protection Act, No. 68, Section 2141(b)(2), (40 P.S. §991.2141) The complaint process shall consist of an initial review to include all of the following:

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(2) The allowance of a written or oral complaint. The denial letter sent to a member on August 3, 2001, incorrectly stated the member would have 60 days from the date of the letter to submit a written grievance for review. A complaint need not be in writing.

Recommendation: None

Response: We note no areas of disagreement. We will reinforce the requirements of the Health Care Accountability and Protection Act, No. 68, Section 2141(b)(2), (40 P.S. §991.2141) with the appropriate personnel.

13. **Consumer Complaints – page 19:**

Violations: 12 for failure to respond to a claimant within 10 working days

Title 31, Pennsylvania Code, Section 146.5 Failure To Acknowledge Pertinent Communication

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry. (c) An appropriate reply shall be made within 10 working days on other pertinent communication from a claimant, which reasonably suggest that a response is expected. The Company failed to respond within the required time frame in 12 claim related complaint files.

Recommendation: The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

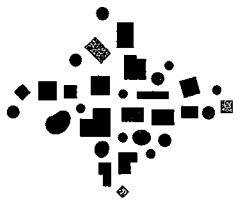
Response: We note no areas of disagreement. We will reinforce the requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair claims Settlement Practices with the appropriate personnel.

14. **Group Policies Issued – pages 21-22:**

Violation: 1 for failing to provide one group account file for review

Insurance Department Act, Section 903 (40 P.S. §323.3) Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any of all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department, at its discretion, may require in order that its authorized representatives may ascertain whether the company or person has complied with the laws of this Commonwealth. The Company failed to provide one group account file for review.

Recommendation: The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a), (40 P.S. §323.3) of the Insurance Department Act.



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Response: We note no areas of disagreement. We will reinforce the requirements of Section 903 with our Small Group Underwriting Department.

15. **Group Policies Declined and Terminated – page 22:**

Violation: 85 for failing to provide evidence of the issuance of Certificates of Creditable Coverage to terminated members.

Health Insurance Portability and Accountability Act, Title XXVII, Section 7201(e), Adopted by the Pennsylvania Health Care Insurance Portability Act, No. 29 (40 P.S. §1302.4). Requirement for certification of period of creditable coverage. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide the certification.

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision.

The Company failed to provide evidence of the issuance of Certificates of Creditable Coverage to 85 terminated members.

Recommendation: The Company must review and revise internal control procedures to ensure compliance with the issuance of the certificates of creditable coverage requirements of the Pennsylvania Health Care Insurance Portability Act, No. 29 (40 P.S. §1302.4).

Response: Since this violation is a violation originating from the Groups Terminated Section of the Initial and Exit Summaries, this section of the Department's Report of Examination of Fortis Insurance Company should be titled Groups Terminated not Group Policies Declined and Terminated. As indicated in the Exit Summary, there were no violations noted in the Group Policies Declined Section.

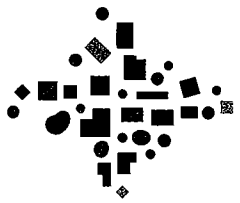
Please be advised that we have taken corrective action to ensure that certificates of creditable coverage are issued in accordance with Pennsylvania law.

16. **Certificateholders Declined Coverage – page 23:**

Violation: 1 file was not provided.

Insurance Department Act, Section 903 (40 P.S. §323.3)
Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the Company or person has complied with the laws of this Commonwealth. The Company failed to provide the file noted.

Recommendation: The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a), (40 P.S. §323.3) of the Insurance Department Act.



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Response: We disagree with the violation as listed. With the exception of one Enrollment Form, we provided the Department with the balance of the small group underwriting file referred to above. We will reinforce the requirements of Section 903 with our Small Group Underwriting Department.

17. **Individual Medical Policies Issued – page 24:**

Violation: 2 applications were not provided.

Insurance Department Act, Section 903 (40 P.S. §323.3)
Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the Company or person has complied with the laws of this Commonwealth. The Company failed to provide applications for the 2 files noted.

Recommendation: The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a), (40 P.S. §323.3) of the Insurance Department Act.

Response: We note no areas of disagreement. We will reinforce the requirements of Section 903 with our Specialty Products Department.

18. **Individual Medical Policies Issued – page 24:**

Violations: 48 applications did not include a replacement question.

Title 31, Pennsylvania Code, Section 88.101
Application forms shall contain a question to elicit information as to whether the insurance to be issued is to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used. The applications in the 48 files noted did not include a replacement question.

Recommendations: The Company must review internal control procedures to ensure compliance with replacement requirements of Title 31, Pennsylvania Code, Chapter 88.

Response: We note no areas of disagreement. We will reinforce the requirements of Title 31, Pennsylvania Code, Chapter 88 with the appropriate personnel.

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19. **Individual Policies Declined – page 26:**

Violations: 3 applications reviewed were illegible.

Insurance Department Act, Section 903 (40 P.S. §323.3)
Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the Company or person has complied with the laws of this Commonwealth. The applications in the 3 files noted were illegible.

Recommendation: The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the Company are maintained in such manner and for such period of time to ensure compliance with Section 903(a), (40 P.S. §323.3) of the Insurance Department Act.

Response: We note no areas of disagreement. We will reinforce the requirements of Section 903(a), (40 P.S. §323.3) with our Individual Medical Underwriting Department.

20. **Individual Policies Declined – page 26:**

Violations: 36 underwriting files did not indicate that the required replacement notice was provided.

Title 31, Pennsylvania Code, Section 88.103 The notice required by §88.102 of this title (relating to delivery to applicant) for an insurer other than a direct response insurer, shall provide a specified replacement notice. Of the 75 declined applications reviewed, 36 applicants indicated on the replacement question in the application that the proposed new coverage would be replacing or changing an existing health insurance plan, but the files noted did not indicate the required replacement notice was provided.

Recommendation: The Company must review internal control procedures to ensure compliance with replacement requirements of Title 31, Pennsylvania Code, Chapter 88.

Response: We note no areas of disagreement. We will reinforce the requirements of Title 31, Pennsylvania Code, Chapter 88 with the appropriate personnel.

21. **Prompt Payment of Provider Claims – page 30:**

Violations: 534 provider submitted clean claims were not paid within the required 45 day time period.

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Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims. (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. A total of 534 provider submitted clean claims were not paid within the required 45 day time period.

Recommendation: The Company must implement procedures to ensure compliance with requirements of Quality Health Care Accountability and Protection Act, No. 68, Section 2166, (40 P.S. § 991.2166), Prompt Payment of Provider Claims.

Response: We respectfully note that we processed 96,423 claims during the time period of the exam. We note no areas of disagreement. We will reinforce the requirements of the Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166 with our Claims Department.

22. **Prompt Payment of Provider Claims – page 30:**

Violation: 1 clean claim did not include the payment of interest

Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims (B) If a licensed insurer or a Managed Care Plan fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars. The Company failed to pay the required interest on the claim noted.

Recommendations: The Company must implement procedures to ensure compliance with requirements of Quality Health Care Accountability and Protection Act, No. 68, Section 2166, (40 P.S. § 991.2166), Prompt Payment of Provider Claims.

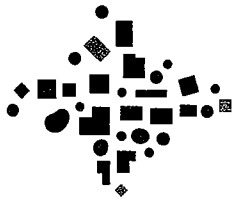
Response: We note no areas of disagreement. We will reinforce the requirements of the Quality Health Care Accountability and Protection Act, No. 68, Section 2166, (40 P.S. § 991.2166), Prompt Payment of Provider Claims with our Claims Department.

23. **Prompt Payment of Provider Claims – page 31:**

Violation: 1 violation for failing to pay interest within 30 days of the payment of the claim.

Title 31, Pennsylvania Code, Section 154.18(c) Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim. The Company failed to pay the required interest within 30 days for the file noted.

Recommendation: The Company must implement procedures to ensure compliance with requirements of Quality Health Care Accountability and Protection Act, No. 68, Section 2166, (40 P.S. § 991.2166), Prompt Payment of Provider Claims.



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Response: We note no areas of disagreement. However, in our previous response to this violation, we provided the Pennsylvania Insurance Department with proof that interest was paid on this claim on February 15, 2003. We will reinforce the requirements of the Quality Health Care Accountability and Protection Act, No. 68, Section 2166, (40 P.S. § 991.2166) with regard to the payment of interest with our Claims Department.

24. **Individual Health Medical Claims – page 31:**

Violation: 1 for failing to acknowledge receipt of a claim within 10 working days of receipt of the claim.

Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. The Company failed to acknowledge receipt of the claim within 10 working days in the file noted.

Recommendation: The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

Response: We note no areas of disagreement. We will reinforce the requirements of Chapter 146 with our Claims Department.

25. **Short Term Medical Claims – page 32:**

Violation: 1 for failing to acknowledge receipt of a claim within 10 working days of receipt of the claim.

Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. The Company failed to acknowledge receipt of the claim within 10 working days in the file noted.

Recommendation: The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

Response: We note no areas of disagreement. We will reinforce the requirements of Chapter 146 with our Claims Department.

26. **Short Term Medical Claims – page 32:**

Violation: 1 for failing to provide status letter to the claimant

Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide status letters in the file noted.

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Recommendation: The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

Response: We note no areas of disagreement. We will reinforce the requirements of Chapter 146 with our Claims Department.

27. **Prescription Drug Claims – page 33:**

Violations: 18 for failing to acknowledge receipt of 18 prescription drug claims within 10 working days of receipt of the claims.

Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. The Company failed to acknowledge receipt of the claim within 10 working days in the 18 files noted.

Recommendation: The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

Response: We note no areas of disagreement. We will reinforce the requirements of Chapter 146 with the appropriate personnel.

28. **Prescription Drug Claims – page 33:**

Violations: 2 for failure to provide status letters to claimants

Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide status letters in the 2 files noted.

Recommendation: Title 31, Pennsylvania Code, Section 146.6 Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide status letters in the 2 files noted.

Response: We note no areas of disagreement. We will reinforce the requirements of Chapter 146 with the appropriate personnel.

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Thank you for the opportunity to respond to the Department's Report of Examination. If you have any questions, please contact me at (414) 299-7854.

Yours sincerely,

Linda M. Tising

Linda M. Tising
Senior Market Conduct Analyst