REPORT OF
MARKET CONDUCT EXAMINATION
OF

TEACHERS PROTECTIVE MUTUAL LIFE INSURANCE COMPANY

Lancaster, Pennsylvania

AS OF
August 27, 2008

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: October 21, 2008

TEACHERS PROTECTIVE MUTUAL LIFE INSURANCE COMPANY

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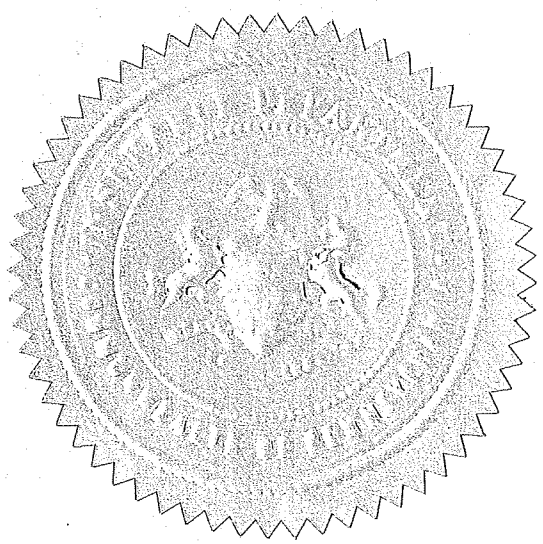
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22ND day of July, 2008, 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 Ronald A. Gallagher, 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.



Joel S. Ario
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
TEACHERS PROTECTIVE MUTUAL LIFE INSURANCE COMPANY 116-118 North Prince Street Lancaster, PA 17608-0597	:	Sections 5(a)(10) and 5(a)(11) of the Unfair Insurance Practices Act, Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§ 1171.5)
	:	
	:	Title 31, Pennsylvania Code, Sections 51.5, 89a.106, 89a.114(f), 146.5, 146.6 and 146.7
	:	
	:	Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)
	:	
Respondent.	:	Docket No. MC08-10-002

CONSENT ORDER

AND NOW, this 2nd day of OCTOBER, 2008, this Order is hereby issued by the Insurance Department 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 Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is Teachers Protective Mutual Life Insurance Company, and maintains its address at 116-118 North Prince Street, Lancaster, Pennsylvania 17608-0597.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from July 1, 2006 through June 30, 2007.

(c) On August 27, 2008, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on September 24, 2008.

(e) After consideration of the September 24, 2008 response, the Insurance Department has modified the Examination Report as attached.

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

(i) The Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.1, et seq.) prohibits unfair claims settlement or compromise practices;

(ii) Section 5(a)(11) of the Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.5), which requires a complete record of all complaints received during the preceding four years;

(iii) Title 31, Pennsylvania Code, Section 51.5, which states a company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth;

(iv) Title 31, Pennsylvania Code, Section 89a.106, which states:

(a) Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following conditions:

(1) Notice before lapse or termination. An individual long-term care poilcy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the

applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or terminatin of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice." The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years.

(2) Deduction Plans. When the policyholder or certificate holder pays premium for a long-term care insruance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (1) need not be met until 60 days after the policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for those

policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long term care policy or certificate may lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing. (b) Reinstatement. In addition to the requirement in subsection (a), a long term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of a past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate;

(v) Title 31, Pennsylvania Code, Section 89a.114(f), which requires every insurer to report annually to the Department by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied;

(vi) Title 31, Pennsylvania Code, Section 146.5, which requires every insurer, upon receiving notification of a claim, shall within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated;

(vii) Title 31, Pennsylvania Code, Section 146.6, which states that if an 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;

(viii) Title 31, Pennsylvania Code, Section 146.7, which requires within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim, and

(ix) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), which requires 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."

CONCLUSIONS OF LAW

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

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

(b) Respondent's violations of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.1 and 1171.5) are punishable by the following, 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.

(c) 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).

(d) Respondent's violations of Title 31, Pennsylvania Code, Sections 89a.106 and 89a.114(f) are punishable under 40 Purdons Statutes, Section 991.1114 which states an insurer or agent found to have violated the requirements relating to the regulations of long-term care insurance or the marketing of such insurance shall be subject to a civil penalty of up to three times the amount of any commissions paid for each policy involved in the violation or $10,000, whichever is greater.

(e) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.5, 146.6 and 146.7 are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10, 1171.11), as captioned above.

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department 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) As of the date of this Order, Respondent agrees to obtain specific written approval from the Department in order to write any long term care business in the Commonwealth of Pennsylvania. A copy of such written approval shall be maintained by Respondent and provided for inspection in the event of a future market conduct examination.

(c) 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.

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

(e) Respondent shall be assessed Thirty-Five Thousand Dollars ($35,000.00) in penalty payable to the Commonwealth of Pennsylvania in settlement of all exceptions contained in this Report. Fifteen Thousand Dollars ($15,000.00) shall be payable no later than 30 days after the date of this Order. The remainder of the penalty amount will be suspended, pending the Respondent's submission of a written corrective action plan in a manner and timeframe acceptable to the Department. The Corrective Action Plan is to provide details including, but not limited to, specific claim processing procedures and other specific actions instituted in order to fully and timely satisfy the Recommendations in the attached Report and the terms of this Consent Order.

(f) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Office Manager, Bureau of Market Conduct, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

(g) In the event that the Department finds, after reasonable investigation, that Respondent has willfully and materially breached the terms of this Consent Order, then any penalty or fine imposed as a result of such finding shall not be limited by the assessment or other limiting provisions of this Consent Order.

6. In the event the Insurance Department 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 Insurance Department 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 Department 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 Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department 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.

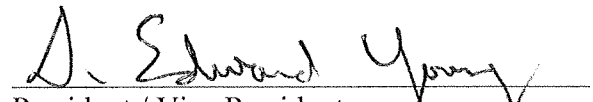
8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

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.

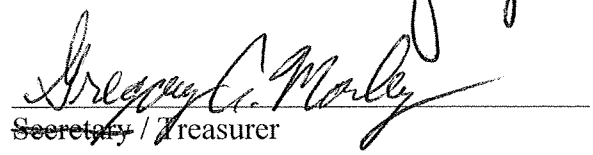
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

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

BY: TEACHERS PROTECTIVE MUTUAL LIFE INSURANCE COMPANY, Respondent



President / ~~Vice President~~



~~Secretary~~ / Treasurer

COMMONWEALTH OF PENNSYLVANIA
By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Teachers Protective Mutual Life Insurance Company; hereafter referred to as "Company," at the Company's office located in Lancaster, Pennsylvania, December 17, 2007, through May 9, 2008. 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 the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by 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 the potential impact upon Company operations or future compliance.

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 officials 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 Officers and Employees of the Company during the course of the examination is acknowledged.

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

Daniel Stemcosky, AIE, FLMI
Market Conduct Division Chief

Gary L. Boose, LUTC
Market Conduct Lead Examiner

Gerald P. O'Hara Jr.
Market Conduct Examiner

Michael T. Vogel
Market Conduct Examiner

Yonise Roberts Paige
Market Conduct Examiner

Verification

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

Gary L. Boose, Examiner-in-Charge

Sworn to and Subscribed Before me

This 31st Day of July, 2008

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
PAMELA L. DAVIS, Notary Public
Whitpain Twp., Montgomery County
My Commission Expires May 6, 2010

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, 2006, through June 30, 2007, unless otherwise noted. The purpose of the examination was to ensure compliance primarily in the Long Term Care (LTC) and Home Health Care (HHC) market.

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

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files 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

Teachers Protective Mutual Life Insurance Company (TPM) originated from The Clergymen's Co-operative Beneficial Association (CCBA), which was chartered on March 18, 1907 to offer disability and life insurance benefits to clergy. It formed a sister company, Teachers Protective Union (TPU) which was incorporated in the Commonwealth of Pennsylvania and received its Certificate of Authority on May 11, 1912. TPU began to offer similar benefits to teaching professionals. On January 4, 1952, TPU was converted to a legal reserve mutual life insurance company named Teachers Protective Mutual Life Insurance Company and began to offer insurance protection to the general public in addition to teachers. The original CCBA was merged into TPM in 1961. The Company is authorized to do business in 10 states and the District of Columbia.

The Company offers a variety of insurance coverage including accident, health, life and disability with the primary focus being products in the small group market. The Company offered individual Long Term Care products from 1992-2005.

As of their 2007 annual statement for Pennsylvania, the Company reported direct premium for ordinary and group life insurance in the amount of $802,522; and direct premium for accident and health insurance in the amount of $20,594,303.

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 this Regulation may be reviewed at any time at the discretion of the Department." The Department, in exercising its discretionary authority for reviewing advertising, requested the Company to provide a copy of the advertising certificate of compliance as required by Title 31, Pennsylvania Code, Section 51.5. The following violation was noted:

1 Violation - Title 31, Pennsylvania Code, Section 51.5 Certificate of Compliance

A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth.

The Company did not provide the required advertising certificate of compliance.

V. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided and forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with Insurance Company Law, Section 354 and Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud notice. The following violations were noted:

3 Violations – Title 18, Pennsylvania Consolidated Statutes, 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."

The following claim forms did not contain or have attached the required fraud statement.

Form Description
Insured Claim Form
Provider Claim Form
Private Caregiver Service Report

VI. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2003, 2004, 2005, 2006 and 2007. The Company reported 4 consumer complaints were received during the experience period. The 4 complaints identified were forwarded from the Department. All 4 complaint files were requested, received and reviewed. The Company provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with Title 31, Pennsylvania Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices.

The following violations were noted:

4 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 for the 4 claim files noted.

2 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within 15 working days for the 2 claim files noted.

3 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)
(40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (i) Misrepresenting pertinent facts or policy or contract provisions relating to coverage's at issue. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the 3 files noted. Policy provisions do not indicate an 80% payment provision and the claim files were not paid timely when proof was present in the file.

VII. UNDERWRITING

The Underwriting review was sorted and conducted in twelve (3) general segments.

A. Underwriting Guidelines
B. Home Health Care Policies Terminated
C. Long Term Care Policies Terminated

Each segment was reviewed for compliance with underwriting practices and included forms identification and producer identification. Issues relating to forms or 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 all underwriting guidelines and manuals utilized during the experience period. The guidelines and manuals received were reviewed to ensure that underwriting guidelines were in place and being followed in a uniform and consistent manner and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. The Company advised the Department of Insurance that no underwriting was done during the experience period. The Company no longer sells long term care insurance. No violations were noted.

B. Home Health Care Policies Terminated

The Company was requested to identify all home health care policies terminated during the experience period. The Company identified 25 home health care policies terminated. All 25 terminated files were requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. The following violations were noted:

5 Violations – Title 31, Pennsylvania Code, Chapter 89a, Section 89a.106. Unintentional lapse.

(a) Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following conditions: Notice before lapse or termination. An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: ''Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I

understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice.'' The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years. (2) Deduction plans. When the policyholder or Certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (1) need not be met until 60 days after the policyholder or Certificate holder is no longer on the payment plan. The application or enrollment form for those policies or certificates shall clearly indicate the payment plan selected by the applicant. (3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate may lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

(b) Reinstatement. In addition to the requirement in subsection (a), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or Certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of a past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit

eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

The 5 files noted did not comply with the protection against unintentional lapse requirements.

1 Violation -Unfair Insurance Practices Act, No. 205, Section 5(a)(11)

(40 P.S. §1171)

Failure to maintain a complete record of all complaints received during the preceding four (4) years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint.

The file noted was not included on the complaint record.

C. Long Term Care Policies Terminated

The Company was requested to identify all policies terminated during the experience period. The Company identified 166 long term care policies terminated. A random sample of 25 long term care policies terminated was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. The following violations were noted:

24 Violations – Title 31, Pennsylvania Code, Chapter 89a, Section 89a.106. Unintentional lapse.

(a) Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following conditions:

(1) Notice before lapse or termination. An individual long-term care policy or certificate may not be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation may not constitute acceptance of liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: ''Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate a person to receive this notice.'' The insured shall be able to change the written designation at any time. The insurer shall notify the insured of the right to change this written designation, at least once every 2 years.

(2) Deduction plans. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (1) need not be met until 60 days after the policyholder or certificate holder is no longer on the payment plan. The

application or enrollment form for those policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long term care policy or certificate may lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated under paragraph (1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing. (b) Reinstatement. In addition to the requirement in subsection (a), a long term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of a past due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity may not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

The 24 files noted did not comply with the protection against unintentional lapse requirements.

VIII. LONG TERM CARE ANNUAL REPORTING

The Company's Long Term Care Annual Reporting for the experience period July 1, 2005 to June 30, 2006 was reviewed to ensure compliance with Title 31, Pennsylvania Code, Chapter 89a. This Chapter establishes Long Term Care Insurance Model Regulations. The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Chapter 89a, Section 89a.114(f)

Every insurer shall report annually to the Department by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (See Appendix E (relating to claims denial reporting form long-term care insurance).)

The Company failed to provide to the Department an Annual Long Term Care Insurance Claims Denial Report by June 30, 2006 for the reporting year 2005 and by June 30, 2007 for the reporting year 2006.

IX. 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 claim manuals:

1. LTC APOC GUIDELINES (disk)
2. LTC CLAIM INSTRUCTIONS (disk)
3. Group Disability Claims Audit Manual (disk)
4. LTC Claim Qualifications (disk)
5. LTC PROCEDURE (disk)

The claim manuals and procedures 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 13 areas:

A. Home Health Care Claims Received
B. Long Term Care Assisted Living Facility Claims Received
C. Long Term Care Alternative Plan of Care Received Claims
D. Long Term Care Facility Claims Received
E. Home Health Care Claims Denied
F. Long Term Care Assisted Living Facility Claims Denied
G. Long Term Care Alternative Plan of Care Claims Denied
H. Long Term Care Facility Claims Denied
I. Home Health Care Claims Paid
J. Long Term Care Assisted Living Facility Claims Paid
K. Long Term Care Alternative Plan of Care Claims Paid
L. Long Term Care Facility Claims Paid
M. Claim Shutdowns

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171) and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Home Health Care Claims Received

The Company was requested to provide a list of home health care claims received during the experience period. The Company identified a universe of 7 home health care claims received. All 7 home health care claim files were requested, received and reviewed. Of the 7 claim files received, two were determined to be a duplicate. The remaining 5 files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

4 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 timely status letters in the 4 claims noted.

1 Violation – Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair

claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the file noted. The Explanation of Benefits (EOB) did not notate what was being paid or denied numerically and verbally.

1 Violation -Unfair Insurance Practices Act, No. 205, Section 5(a)(11)
(40 P.S. §1171)

Failure to maintain a complete record of all complaints received during the preceding four (4) years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint.

The file noted was not included on the complaint record.

B. Long Term Care Assisted Living Facility Claims Received

The Company was requested to provide a list of long term care assisted living facility claims received during the experience period. The Company identified a universe of 13 long term care assisted living facility claims received during the experience period. All 13 long term care assisted living facility claim received files were requested, received and reviewed. The 13 files were reviewed for compliance with Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5) and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

13 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 13 claim files noted.

3 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within 15 working days in the 3 claims noted.

8 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)
(40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the noted claim files. The claim files were not paid timely when proof was present in the file and the Explanation of Benefits (EOB) did not notate what was being paid or denied numerically and verbally.

C. Long Term Care Alternative Plan of Care Received Claims

The Company was requested to identify all claims received during the experience period. The Company identified 21 long term care alternative plan of care claims received. One file was a Virginia claim and was not reviewed. The remaining 20 claims were requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. The following violations were noted:

13 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 timely status letters for the 13 claims noted.

4 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within 15 working days in the 4 claims noted.

9 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)

(40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (i) Misrepresenting pertinent facts or policy or contract provisions relating to Coverages at issue. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the noted files. Policy provisions do not indicate an 80% payment provision. The claim files were not paid timely when proof was present in the file and the Explanation of Benefits (EOB) did not notate what was being paid or denied numerically and verbally.

D. Long Term Care Facility Claims Received

The Company was requested to identify all claims received during the experience period. The Company identified 18 long term care facility claims received. All 18 claims were requested and received. Claim file 16 was not reviewed as it was a duplicate of file 15. All the other 17 files were reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.5 Failure to Acknowledge Pertinent Communication

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(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 communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable

requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

There was no evidence that the Company provided the claimant with instructions and reasonable assistance so the claimant could comply with requirements of the insurer to process the claim for the claim file noted.

17 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 timely status letters for the 17 claims noted.

6 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within 15 working days in the 6 claims noted.

6 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)
(40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) Failing to affirm or deny coverage of

claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the 6 claim files noted. The claim files were not paid timely when proof was present in the file.

E. Home Health Care Claims Denied

The Company was requested to provide a list of home health care claims denied during the experience period. The Company identified a universe of 4 home health care claims denied. All 4 home health care denied files were requested, received and reviewed. Of the 4 claim files denied, one file was a duplicate. The remaining 3 files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were 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 timely status letters in the 2 claims noted.

F. Long Term Care Assisted Living Facility Claims Denied

The Company was requested to provide a list of long term care assisted living facility claims denied during the experience period. The Company identified a universe of 1 long term care assisted living facility claim denied. One long term care assisted living facility claim denied file was requested, received and reviewed. The file was reviewed for compliance with Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5) and Title 31, Pennsylvania Code, Chapter 146. The following violation was 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 timely status letters in the claim noted.

G. Long Term Care Alternative Plan of Care Claims Denied

The Company was requested to provide a list of long term care alternative plan of care claims denied during the experience period. The Company identified a universe of 5 long term care alternative plan of care claims denied. All 5 long term care alternative plan of care claim denied files were requested, received and reviewed in another section of the exam. The files were reviewed for compliance with Unfair Insurance

Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5) and Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

H. Long Term Care Facility Claims Denied

The Company was requested to provide a list of long term care facility claims denied during the experience period. The Company identified a universe of 1 long term care facility claims denied. The long term care facility claim denied file was requested, received and reviewed in another section of the exam. The files were reviewed for compliance with Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5) and Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

I. Home Health Care Claims Paid

The Company was requested to provide a list of home health care claims paid during the experience period. The Company identified a universe of 153 home health care claims paid. A random sample of 25 home health care paid files were requested and received. Of the 25 files received, one file was determined to be a duplicate from another section of the exam. The remaining 24 files were reviewed for compliance with Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5) and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

3 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within 15 working days in the 3 claims noted.

10 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)
(40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the noted files. The claim files were not paid timely when proof was present in the file. The Explanation of Benefits (EOB) did not notate what was being paid or denied numerically and verbally.

J. Long Term Care Assisted Living Facility Claims Paid

The Company was requested to provide a list of claims paid during the experience period. The Company identified a universe of 401 long term care claims paid. A random sample of 50 claims was requested and received. Of the 50 files received, 8 files were determined to be duplicates from another section of the exam. The remaining 42 files were reviewed for compliance with Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5) and Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.5

(a) 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. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

The Company failed to acknowledge the claim within 10 working days.

25 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or

performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company has committed or performed the above act with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the 25 claim files noted. The Explanation of Benefits (EOB) did not notate what was being paid or denied numerically and verbally.

K. Long Term Care Alternative Plan of Care Claims Paid

The Company was requested to identify all claims paid during the experience period. The Company identified 359 long term care alternative plan of care claims paid. A random sample of 25 claims was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. The following violations were noted:

2 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. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.

The Company failed to acknowledge the claim within 10 working days for the 2 claims noted.

2 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days in the 2 claims noted.

28 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (i) Misrepresenting pertinent facts or policy or contract provisions relating to Coverages at issue. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the 28 files noted. Policy provisions do not indicate an 80% payment provision. The claim files were not paid timely when proof was present in the file and the Explanation of Benefits (EOB) did not notate what was being paid or denied numerically and verbally.

L. Long Term Care Facility Claims Paid

The Company was requested to identify all claims received during the experience period. The Company identified 260 long term care facility claims paid. A random sample of 50 claims was requested, received reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within 15 working days for the 2 claims noted.

6 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)
(40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the 6 claim files noted. The claim files were not paid timely when proof was present in the file and the Explanation of Benefits (EOB) did not notate what was being paid or denied numerically and verbally.

M. Claim "Shutdowns"

The Company provided a copy of the Claims Procedure. During the review of the Company's Long Term Care Claim Instructions, the Company indicated a procedure in place entitled "Shutdown." In an email, the Company defined a "Shutdown" as: "an inquiry asking for information or expressing that the insured wants to pursue a claim. If through the intake call it is found that what the caller is asking for does not meet the terms of the policy (policy triggers), or they are just inquiring about benefits, then this inquiry does not become a claim. A claim begins when all required claim forms and information is received that there has been expense incurred to review and determine if this information constitutes a claim."

The Company indicated "Shutdowns" are not logged, the examiners do not keep records and only the Long Term Care Coordinator may keep information if she thinks it may turn into a claim. The Department requested a list of all "Shutdown" records. The Company identified 10 "Shutdown" files. Since the Company does not require this data to be documented, the 10 files identified is not representative of all the "Shutdown" calls. All 10 files were requested, received and reviewed. The Company later advised that two files were from Virginia. The files were reviewed to ensure compliance with contract provisions, Title 31, Pennsylvania Code, Section 146, Unfair

Claims Settlement Practices, and the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). The following violation was noted:

1 Violation – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)
(40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

The Company has a claims procedure in the Long Term Care Claim Instructions entitled "Shutdown." The calls are not logged and documented. The definition and practice could be indicative of unaddressed claims and inappropriate denial of claims. The telephonic process and handling of an insured's initiation of a claim fails to meet reasonable standards for the prompt and effective investigation of claim.

X. 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 the fraud statement notice requirements of Title 18, Pennsylvania Consolidated Statutes Section 4117(k).

2. The Company must review and revise internal control procedures to ensure compliance with the filing, suitability and disclosure requirements of Title 31, Pennsylvania Code, Chapter 89a. Long-Term Care Model Regulation

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 implement procedures to ensure compliance with the complaint maintenance requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).

5. The Company must implement procedures to ensure advertising certification requirements of Title 31, Pennsylvania Code, Chapter 51.

6. The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).

7. The Company must review and revise claim handling procedures to ensure reasonable standards for the prompt investigation of claims are adopted as required by Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).

XI. COMPANY RESPONSE

TEACHERS PROTECTIVE MUTUAL
LIFE INSURANCE COMPANY
116-118 North Prince Street, P.O. Box 597
Lancaster, PA 17608-0597
717-394-7156 FAX 717-394-7024

D. EDWARD YOUNG
PRESIDENT & CEO

September 24, 2008

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

RE: Examination Warrant Number: 07-M26-039
Report of the Market Conduct Examination of
Teachers Protective Mutual Life Insurance Company

Dear Mr. Stemcosky:

This letter is in response to Market Conduct Examination Report of Teachers Protective Mutual Life Insurance Company dated August 27, 2008. We kindly ask that the letter be included with any public dissemination of the Examination Report to allow readers of the report to see our response to the findings detailed in the report.

The Market Conduct Exam was very helpful in identifying areas where our business processes and procedures needed improvement. These changes will be beneficial to our policyowners. As a small mutual insurance company, we are dedicated to providing our policyowners fair and equitable treatment based on the insurance contract they purchased from us. In our efforts to provide personal claim service, we did not always adequately document and communicate with claimants. We have implemented changes to correct these deficits.

Changes were implemented to correct all deficiencies identified in the exam in advance of completion of the audit. A copy of all revised forms and procedures was emailed to the examiner in charge on July 30. 2008.

Thank you for the courtesies that you have extended my staff and me in the review process. Attached in Exhibit A is our response to the Recommendations contained in the report and comments on specific areas that we felt deserved further clarification.

Sincerely,

D. Edward Young

D. Edward Young
President & CEO

Exhibit A

Teachers Protective Mutual
Life Insurance Company

Comments on Recommendations
In Market Conduct Report
Examination Warrant Number 07-M26-039

1. The Company has implemented procedures, as of February, 2008, to assure compliance with Title 18, Pennsylvania Consolidated Statutes Section 4117(k) by affixing the required fraud notice to the following forms, specimens of which were provided to the Department in late July:

A. Insured Claim Form, Form No. **PAPRCF11220080103R20080108**;
B. Provider Claim Form, Form No. **PALTCICF10320080103R20080108**;
C. Private Caregiver Service Report, Form No. **PALTCPCSR11120080103**.

2. The Company changed internal control procedures to ensure compliance with the filing, suitability and disclosure requirements of Title 31, Pennsylvania Code, Chapter 89a. In so far as specific violations are alleged under Chapter 89a, the Company has taken the following action:

A. With respect to Unintentional Lapse under Section 89a.106, the Company put into place a procedure under which the Company will mail the right to change the third party lapse designation once every year. The first annual mailing to active policyholders occurred on May 2, 2008. A specimen copy of the mailing notice was supplied to the Department in late July.

B. With respect to lapse notices under 89a.106(a)(3), the Company put into place a procedure on or about January 15, 2008 whereby the policyholder will receive notice of policy lapse at least 30 days after a premium is due and unpaid and lapse for non-payment will not occur until at least 30 days after the aforementioned notice has been given (5 days after date of mailing). A specimen of the notice was supplied to the Department in late July.

C. The Company agrees to file on a timely basis the annual report required by 89a.114(f) with respect to qualified long-term care policies. Copies of the relevant reports for calendar years 2005 and 2006 were filed with the Department of Insurance on or about July 27, 2007. The report for calendar year 2007 was received by the Department on January 28, 2008. Copies of these notices and proof of receipt were sent to the Department in late July.

3. The Company has reviewed and revised internal control procedures to ensure compliance with the requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices, specifically completion of investigation of claim; delay notice; acceptance or denial of claim; acknowledgment of pertinent communications, claims and provision of necessary forms and instructions or

assistance. It should be noted that in the past the Company often assisted the policyholder/claimant by working directly with their health care provider to make sure the appropriate forms were completed in order to properly adjudicate the claim as quickly as possible. However, the Company did not adequately keep the policyholder informed of where the claim stood and that is the reason for numerous violations. The Company has amplified its existing procedures to require written documentation of each event and discontinued the process of oral communication to policyholder/claimants and/or providers without an accompanying written business record The Company has instructed its staff relative to the timeliness of action needed to be taken and has charged outside regulatory counsel to review guidelines for the Company's claim manual(s) and suggest any changes as appropriate. Copies of revised processes and procedures were sent to the Department in late July.

4. The Company has implemented procedures to ensure compliance with the complaint maintenance requirements of Section 5 of the Unfair Insurance Practices Act via verbal and written reminders to personnel of the importance of maintaining a complete record of all complaints received so as to preclude even the couple of violations that occurred during the period of examination.

5. The Company has implemented procedures to ensure advertising certification requirements even if, as here, no advertisements were utilized, to comply with Title 31, Pennsylvania Code, Chapter 51. The requisite Certificate of Compliance has been added to the Company's "check list" for annual statement completion and filing. It should be noted that the Required Filings Checklist for Pennsylvania as provided by the Insurance Department annually indicated that a "Certificate of Compliance" was not required to be filed. This was modified for 2008 with a footnote that stated that an Advertising Certificate of Compliance is required to be filed annually. It is our understanding that this has been a confusing issue for a number of insurers.

6. The Company has and continues to review internal control procedures to ensure compliance with the prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act.

A. The Company believes it was compliant with respect to disclosure of what was being paid or denied numerically and verbally via written alternative plans of care established with claimants beforehand. While the explanation of benefits used for claim payments during the examination period did not have a place to show denied amounts, there was virtually never a question from an insured or provider as to the amount paid as that had been clearly communicated at time the claim was approved. In addition, a review of a number of the claims cited, especially those with Alternative Plans of Care, did not have any denied claim amounts. The Company has developed a worksheet as part of the Explanation of Benefits form to clearly indicate denied amounts which should demonstrate compliance with Section 5. Copies of the EOB with the worksheet were included with the all the materials furnished to the Department in late July.

B. The "80% payment guideline," as it applies to alternative plans of care, was noted in 5 claims examined, involving 3 insureds. It is the Company's belief this was a fair settlement of claims where policy benefits were extended when no contractual right existed to the type of service rendered or provider utilized. The "80%" is consistent with the intended purpose of alternative plans of care - i.e. - cost efficiency without sacrifice of quality of care. The Department of Insurance must also note that industry statistics demonstrate that home health care is less costly than institutional care and private caregivers are less expensive than home health care agencies who have overhead and exist to make a profit in most instances.

C. The Company acknowledges that not all claim payments were made on a timely basis and has, as stated in item (3) above, amplified and refined its existing procedures to ensure compliance.

D. The Company strenuously objects to any allegation or suggestion that it has acted in bad faith. "Bad faith" encompasses intentional acts taken by one with a furtive mind operating to create ill will. The Company believes that its low complaint numbers in this particular line of business; the acknowledged courtesy and cooperation extended to the Department of Insurance; and the Company's immediate actions to preclude repetition of any violations - technical or substantive - are indicia of quite the opposite or good faith.

7. The Company, as previously stated above, has and continues to review and refine claim handling procedures to ensure reasonable standards for the prompt investigation of claims as required by Section 5 of the Unfair Insurance Practices Act.

We would like to assure the Department that Teachers Protective Mutual Life is committed to full compliance with all regulatory requirements.

Sincerely,

D. Edward Young

D. Edward Young
President & CEO