COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

CONSECO HEALTH INSURANCE COMPANY

Carmel, IN

As of: May 27, 2011
Issued: July 18, 2011

MARKET ACTIONS BUREAU
LIFE AND HEALTH DIVISION

CONSECO HEALTH INSURANCE COMPANY

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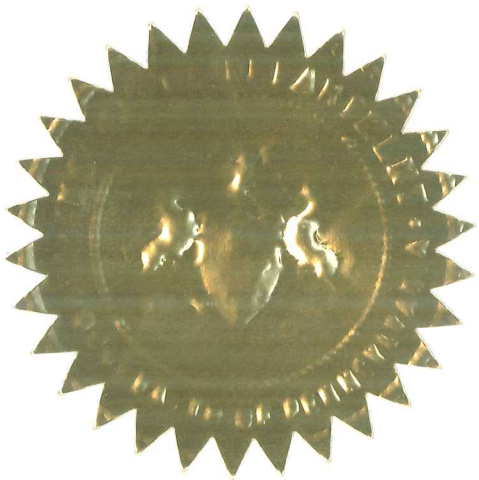
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27th day of April, 2011, 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.



Michael F. Consedine
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
CONSECO HEALTH INSURANCE COMPANY 11825 N. Pennsylvania Street Carmel, IN 46032	:	Sections 5(a)(10)(ii)(iii)(v) 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 18, Pennsylvania Consolidated Statutes, Section 4117(k)
	:	Title 31, Pennsylvania Code, Sections 146.5(a), (b), (c) and (d), 146.6 and 146.7
Respondent.	:	Docket No. MC11-07-005

CONSENT ORDER

AND NOW, this 18th day of July, 2011, 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 Conseco Health Insurance Company, and maintains his address at 11825 N. Pennsylvania Street, Carmel, Indiana 46032.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the experience periods from January 1, 2009 through December 31, 2009.

(c) On May 27, 2011, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on June 22, 2011, and a redacted company response was received on June 24, 2011.

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

(i) Section 5(a)(10)(ii)(iii)(v) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.5), which states 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:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(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.

(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 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".

(iv) Title 31, Pennsylvania Code, Section 146.5(a), which states 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. 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;

(v) Title 31, Pennsylvania Code, Section 146.5(b), which states every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry;

(vi) Title 31, Pennsylvania Code, Section 146.5(c), which states an appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected;

(vii) Title 31, Pennsylvania Code, Section 146.5(d), requires an insurer, upon receiving notification of a claim, shall provide within ten working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer;

(viii) Title 31, Pennsylvania Code, Section 146.6 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; and

(ix) Title 31, Pennsylvania Code, Section 146.7, which requires within 15 working days after receipt by the insurer of properly executed proof of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer.

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 Sections 5(a)(10)(ii)(iii)(v) and 5(a)(11) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 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 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 and 1171.11), as described 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) 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) To determine Respondent's compliance with the full and timely implementation of all recommendations ("Recommendations") in the Examination Report, Respondent shall perform a self-audit of all issues addressed in the "Recommendations" section of the 2011 Conseco Health Insurance Company Market Conduct Examination Report. The self-audit shall be performed based on the following: The experience period will be from January 1, 2012 through June 1, 2012. The self-audit shall commence on July 1, 2012 and the results of the self-examination shall be provided in writing to the Pennsylvania Insurance Department on or before October 1, 2012.

(d) Following the completion of the self-audit, the Pennsylvania Insurance Department reserves the right to call a targeted market conduct re-examination to determine compliance with the recommendations from the examination report, the scope of which shall not include the period six (6) months after the effective date of the Consent Order.

(e) Respondent shall pay Twenty-Five Thousand Dollars ($25,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(f) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, 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.

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: CONSECO HEALTH INSURANCE COMPANY, Respondent

William D. Smith, Jr.

~~President~~ / Vice President (Senior), Regulatory and Government Affairs

Karl W Kindig

Secretary / ~~Treasurer~~

Ronald A. Gallagher

RONALD A. GALLAGHER, JR.
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination was conducted on Conseco Health Insurance Company; hereafter referred to as "Company," at the Company's office located in Indianapolis, Indiana, October 18, 2010, through February 18, 2011. 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 laws, 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 violations. An exit conference was conducted with Company officials to review written summaries and to discuss the examination results.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Yonise A. Roberts Paige
Chief, Life, Accident & Health Division
Market Action Bureau

Lonnie Suggs
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).

Lonnie L. Suggs

[Examiner in Charge]

Sworn to and Subscribed Before me

This 15th Day of MARCH, 2011

Notary Public

DEBBIE J. JOHNSON
Notary Public - Notary Seal
State of Missouri
Commissioned for Jackson County
My Commission Expires: May 13, 2013
Commission Number: 09788310

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 January 1, 2009, through December 31, 2009, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws, statutes and regulations.

The examination was a target examination that focused on the Company's business practice in areas such as: Consumer Complaints, Policy Forms and Filing, Internal Audit and Compliance Procedures 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

The Company was organized and incorporated as Capitol American Life Insurance Company; a domestic limited stock life and disability insurer under the laws of the State of Arizona on October 6, 1970, and received its first Certificate of Authority as a domestic limited stock life and disability insurer on November 25, 1970. On December 13, 1971, the Company was issued a Certificate of Authority to operate as a full legal reserve life and disability insurer and is presently so authorized. On April 21, 1984, the Company's Certificate of Authority was amended to reflect Scottsdale, Arizona, as the Company's principal place of business. Effective April 30, 1991, the Company changed its known or principle place of business to Phoenix, Arizona.

By Order dated December 6, 1996, the Company was acquired by Conseco, Inc. The acquisition was effective March 4, 1997, upon the acquisition of the Company's then parent, Capitol American Financial Corporation, by Conseco, Inc.

In June of 1997, the Company's administrative functions moved to Carmel, Indiana and the claims payment and processing were moved to Chicago, to realize the operating efficiencies of consolidating its operations with the other life insurance companies owned by Conseco, Inc.

Effective April 1, 1998, Capitol National Life Insurance Company, NAIC #73032, an Ohio insurer and a wholly owned subsidiary, was merged into the Company by Order dated March 20, 1998.

Effective June 26, 1998, the name of the Company was changed to Conseco Health Insurance Company, NAIC # 78174.

Effective June 30, 1999, the Company's then parent, Capitol American Financial Corporation merged into and with CIHC, Incorporated (CIHC). CIHC then contributed 100% of the outstanding common stock of the Company to Conseco Life Insurance Company of Texas, NAIC #88480. By Order dated October 1, 1999, the transaction was approved by the Texas Insurance Commissioner.

Effective March 31, 2000, the Company assumed 100% of the insurance policies inforce for Capitol Insurance Company of Ohio, NAIC #60087, a mutual assessment life and accident association. Capitol Insurance Company of Ohio was subsequently dissolved effective March 23, 2001.

Effective July 1, 2001, Frontier National Life Insurance Company (FNLIC), NAIC # 99260, an Ohio domestic insurer and a wholly owned subsidiary, was merged into the Company. By Order dated June 27, 2001, the transaction was approved by the Arizona Department of Insurance.

On December 17, 2002, Conseco, inc., an Indiana corporation and the Company's ultimate controlling entity, and CIHC, and upstream parent of the Company, filed voluntary petitions for reorganization under Chapter 11 of the United States Bankruptcy Code. Effective September 10, 2003, after receiving court approval of the sixth amended plan of reorganization of Conseco, Inc., and upon such plan becoming effective, Conseco, Inc., a Delaware corporation, became the ultimate parent company. By Order dated September 5, 2003, the acquisition was approved by the Arizona Department of Insurance.

On September 12, 2003 CIHC was merged into CIHC Incorporated of Texas, which then converted to a Texas insurance company named CIHC Life Insurance Company of Texas, NAIC # 11804. Conseco Life Insurance Company of Texas was merged into

CIHC Life Insurance Company of Texas. The surviving company was renamed Conseco Life Insurance Company of Texas, NAIC # 11804.

Company Overview

Conseco Health Insurance Company ("CHIC") is a direct subsidiary of Washington National Insurance Company, an indirect subsidiary of CNO Financial Group, Inc. The Company is domiciled in the state of Arizona and licensed in every state except for Connecticut, New York and Massachusetts. The Company is also licensed in the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Conseco Health Insurance Company services supplemental health insurance and life insurance customers. Universal Fidelity Life Insurance Company administers the Company's Medicare Supplement claims.

As of the Company's December 31, 2009, annual statement for Pennsylvania, Conseco Health Insurance Company reported direct premiums for life insurance considerations in the amount of $32,630 and direct premiums for accident and health insurance in the amount of $9,989,924 and premiums earned for Medicare supplement insurance in the amount of $2,352,694.

IV. POLICY FORMS AND FILING

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.

13 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 noted 13 application forms did not contain the required fraud statement.

V. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period of January 1, 2009 through December 31, 2009. The Company was also requested to provide copies of consumer complaint logs for 2005, 2006, 2007 and 2008. The Company identified 4 consumer complaints received during the experience period. All 4 complaint files were requested, received and reviewed. The company also provided complaint logs as requested. 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, PA Code, Chapter 146. Unfair Insurance Practices. The following violations were noted:

4 Violations - Unfair Insurance Practices Act, No. 205, Section 5 (a)(11)

Failure of any person to maintain a complete record of all the complaints which it has 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. For purposes of this paragraph, “complaint” means any written communication primarily expressing a grievance. The 2005, 2006, 2007 and 2008 complaint logs were missing the total number of complaints and the time it took to process each complaint.

VI. INTERNAL AUDIT AND COMPLIANCE PROCEDURES

The Company was requested to provide copies of their internal audit and compliance procedures. The audit procedures provided 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.

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.

The Company provided the following:

- Internal Audit Procedures – 2009 Audit Program

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VII. CLAIM MANUALS & 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. Claims Audits – Random audits on auditor released claims
2. Claim Bulletins
   - Updated Mammogram Procedures
   - Requesting Documents to Process Claims
   - Overpayment Procedures
   - Spousal Knowledge of Pre-Malignant Conditions
   - Exemptions of Life Insurance and Related Benefits for Attachment by Creditors.
   - New State Interest Chart
3. Heart Stroke/Cancer/ICU Audit Guidelines
4. Memo – Claim Investigation For Rescission
5. Health Claims Prompt payment And Interest Survey Sheet By State
6. Annuity State Tax Table – 12/2006
7. Community Property By State
8. General Overview – 2010 Medicare
   - Electronic Claim Process
   - Paper Claims
   - Universal Fidelity Life (UFL) Manual Processing
9. Life And Annuity Claim Payment Interest Requirements – By State
10. Life Waiver – Procedural Guidelines and Claims Handling
11. Life End Waiver Procedures
12. Medicare Supplement Claims – Training and Development Manual
13. Non-Resident Alien Tax Reporting
14. Contents For Letters and Corr Codes to Policyholders
15. Delay Letter Codes
16. Guide For Problematic Corr Codes – Corr Code Guide
17. Small Estates Administration – 50 State Survey
18. Life Claims Legislative Reference
    - PA Divorced Spouse Beneficiary
    - PA Fraud Reporting Requirements

- Fraud Notice on Claim Forms and Applications
- PA Minors Beneficiary's Right To Receive Payment
- PA Non-Probate of Will and Distribution of Small Estates
- PA Post Mortem Interest

19. PA Unfair Claims Settlement Practices
20. Regulation 31 §§146.5 to 146.7
    - Failure To Acknowledge Pertinent Communication
    - Standards For Prompt Investigations of Claims
    - Standards For prompt, Fair, and Equitable Settlements Applicable to all Insurers

    Use of UTMA (Uniform Transfers to Minors Act) Designations

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. Whole Life Claims Paid
B. Accident Claims Paid
C. Accident Claims Denied
D. Cancer Claims Paid
E. Cancer Claims Pending
F. Cancer Claims Denied
G. Heart Stroke Claims Paid
H. Heart Stroke Claims Denied
I. Intensive Care Unit Claims Paid
J. Intensive Care Unit Claims Denied
K. Medicare Supplement Claims Paid
L. Medicare Supplement Claims Pending
M. Medicare Supplement Claims Denied

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. Whole Life Claims Paid

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 4 whole life claims paid during the experience period. All 4 claim files were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. Unfair Insurance Practices, and Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b). The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.6

(a) Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such 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. Verification of a day timely status letter could not be established in the noted claim file.

B. Accident Claims Paid

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 88 accident claims paid. All 88 claim files were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

7 Violations - Title 31, Pennsylvania Code, Section 146.5. Failure to acknowledge pertinent communications

(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 who reasonably suggests 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). Verification of an acknowledgement could not be established within 10 working days of notification in the 7 noted claim files.

8 Violations - Title 31, Pennsylvania Code, Section 146.6

(a) Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such 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. Verification of a 45 day timely status letter could not be established in the 8 noted claim files.

12 Violations - Title 31, Pennsylvania Code, Section 146.7

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. Verification of acceptance or denial within 15 working days could not be established in the 12 noted claim files.

12 Violations - Unfair Insurance Practices Act, No. 205 Section 5 (a)(10)(ii)(iii)(v)

(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:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(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 12 noted claim files were adjudicated with "Unfair Methods of Competition" and/or "Unfair or Deceptive Acts or Practices."

C. Accident Claims Denied

The Company was requested to provide a list of accident claims denied during the experience period. The Company identified a universe of 29 accident claims. All 29 accident claim files were requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

4 Violations - Title 31, Pennsylvania Code, Section 146.5. Failure to acknowledge pertinent communications

(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 who reasonably suggests 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). Verification of an acknowledgement could not be established within 10 working days of notification in the 4 noted claim files.

2 Violations - Title 31, Pennsylvania Code, Section 146.6

(a) Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such 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. Verification of a timely status letter could not be established in the 2 noted claim files.

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 insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the 2 noted claim files.

6 Violations - Unfair Insurance Practices Act, No. 205 Section 5 (a)(10)(ii)(iii)(v)

(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:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(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 6 noted claim files were adjudicated with "Unfair Methods of Competition" and/or "Unfair or Deceptive Acts or Practices."

D. Cancer Claims Paid

The Company was requested to provide a list of cancer claims received during the experience period. The Company identified a universe of 532 paid cancer claims. A

sampling of 100 cancer claim files were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

3 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. Verification of a timely status letter could not be established in the 3 noted claim files.

10 Violations - Title 31, Pennsylvania Code, Section 146.7

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. Verification of acceptance or denial within 15 working days could not be established in the 10 noted claim files.

10 Violations - Unfair Insurance Practices Act, No. 205 Section 5 (a) (10)(ii)(iii)(v)

(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:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(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 10 noted claim files were adjudicated with "Unfair Methods of Competition" and/or "Unfair or Deceptive Acts or Practices."

E. Cancer Claims Pending

The Company was requested to provide a list of all cancer claims received during the experience period. The Company identified a universe of 1 cancer claim pending file. The 1 cancer claim file was requested, received and reviewed. The file was reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. Unfair Insurance Practices. The following violation was noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.5

(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 who reasonably suggests that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within10 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). Verification the company acknowledged claims within 10 working days could not be established in the noted claim file.

F. Cancer Claims Denied

The Company was requested to provide a list of cancer claim files denied during the experience period of January 1, 2009 through December 31, 2009. The Company identified a universe of 178 denied cancer claim files. A random sample of 50 cancer claim files was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted.

9 Violations - Title 31, Pennsylvania Code, Section 146.5. Failure to acknowledge pertinent communications

(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 who reasonably suggests that a response is expected.
(d) Every insurer, upon receiving notification of claim, shall provide within10 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). Verification the company acknowledged claims within 10 working days could not be established in the 13 noted claim files.

5 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. Verification of a timely status letter could not be established in the 5 noted claim files.

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 insurer shall advise the first-party claimant of the acceptance or denial of the claim. Verification of acceptance or denial within 15 working days could not be established in the 6 noted claim files.

G. Heart Stroke Claims Paid

The Company was requested to provide a list of heart stroke claims received during the experience period. The Company identified a universe of 9 heart stroke claims paid. All 9 heart stroke claim files were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. Unfair Insurance Practices. The following violations were 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. Verification of a timely status letter could not be established in the noted claim file.

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. Verification of acceptance or denial within 15 working days could not be established in the 2 noted claim files.

2 Violations - Unfair Insurance Practices Act, No. 205 Section 5 (a)(10)(ii)(iii)

(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:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

The 2 noted claim files were adjudicated with "Unfair Methods of Competition" and/or "Unfair or Deceptive Acts or Practices."

H. Heart Stroke Claims Denied

The Company was requested to provide a list of all heart stroke claims received during the experience period. The Company identified a universe of 8 heart stroke claim files denied. All 8 heart stroke claim files denied were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. Unfair Insurance Practices. No violations were noted.

I. Intensive Care Unit Claims Paid

The Company was requested to provide a list of all intensive care unit claims received during the experience period. The Company identified a universe of 1 intensive care unit claim paid file. The intensive care unit claim paid file was requested, received and reviewed. The file was reviewed for compliance with Title 31, Pennsylvania code, Chapter 146. Unfair Insurance Practices. No violations were noted.

J. Intensive Care Unit Claims Denied

The Company was requested to provide a list of intensive care claims received during the experience period. The Company identified 162 intensive care claims received. A

random sample of 25 claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). No violations were noted.

K. Medicare Supplement Insurance Claims Paid

The Company was requested to provide a list of all Medicare supplement insurance claim files received during the experience period. The Company identified a universe of 798 Medicare supplement insurance claim files paid during the experience period. A random sample of 150 Medicare supplement insurance claim files paid were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

6 Violations - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications.

(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 suggests 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). Verification of acknowledgement within 10 working days could not be established in the 8 noted claim files.

3 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. Verification of a timely status letter could be established in the 3 noted claim files.

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. Verification of acceptance or denial within 15 working days could not be established in the 3 noted claim files.

L. Medicare Supplement Insurance Claims Pending

The Company was requested to provide a list of all Medicare supplement insurance claim files received during the experience period. The Company identified a universe of 8 Medicare supplement insurance claim files pending during the experience period. All 8 Medicare supplement insurance claim files were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. Unfair Insurance Practices. The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications.

(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 who reasonably suggests 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). Verification

the company acknowledged claims within 10 working days could not be established in the 2 noted claim files.

3 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. Verification of a timely status letter could be established in the 7 noted claim files.

7 Violations - Unfair Insurance Practices Act, No. 205 Section 5 (a)(10)(ii)(iii)

(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:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

The 7 noted claim files were adjudicated with "Unfair Methods of Competition" and/or "Unfair or Deceptive Acts or Practices."

M. Medicare Supplement Insurance Claims Denied

The Company was requested to provide a list of all Medicare supplement insurance claim files received during the experience period. The Company identified a universe of 411 Medicare supplement insurance claim files denied. A random sample of 100

Medicare supplement insurance claim files denied was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. Unfair Insurance Practices. The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section 146.5. Failure to acknowledge pertinent communications

(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 who reasonably suggests 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). Verification the company acknowledged claims within 10 working days could not be established in the 2 noted claim files.

VIII. 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 review and revise procedures to ensure the proper adherence to the fraud language requirements as stated by Title 18, Pennsylvania consolidated Statues, Section 4117(k)

2. The Company must implement procedures to ensure compliance with the requirements of Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance – Act 205, Section 5 (40 P.S. §1171.5).

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.

IX. COMPANY RESPONSE

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CNO FINANCIAL GROUP

Via FedEx and E-Mail

June 22, 2011

Yonise Roberts Paige
Chief Life, Accident and Heath Division
Bureau of Market Action
1321 Strawberry Square
Harrisburg, PA 17120

RE: Conseco Health Insurance Company Market Conduct Examination
Examination Warrant Number: 10-M27-058

Dear Ms. Paige:

Please accept this correspondence as Conseco Heath Insurance Company's (hereinafter referred to as the "Company") formal written submission or rebuttal to the Examination Report dated May 27, 2011 pursuant to 40 P.S. § 323.5. For your convenience, the specific sections which the Company is formally responding to are noted below.

In its response below, the Company references information contained in confidential examination workpapers. The Company, by reference thereto, does not intend to waive any rights of confidentiality or privilege regarding these matters.

IV. Policy Forms and Filing

The Company disagrees that 13 application forms did not contain the required fraud statement. In its formal response to the Initial Summary, the Company provided the following basis for its disagreement with these violations:

Company Response:
The Company disagrees with 11 of these violations. Eleven of the application forms were approved prior to the effective date (2/26/95) of Section 4117(k), regarding fraud language. Therefore they are not in violation. The Company agrees two application forms (CL000/AA2PA-BJP and CL000/AU2PA-BJP) were approved by the Department after the

> *effective date of the applicable code and do not include the fraud language. These applications were used for products which have not been marketed for a number of years.*

The Department stated in response:

> ***Department Response**: Violations stand – Company agrees with 2 of the violation.(sic) All applications and claim form (sic) must contain or have attached thereto the required fraud statement. The Department could not verify this requirement has been complied with in the remaining 11 forms.*

For the Department to allow for the violations to remain in the Examination Report would be contrary to section 1926 of the Statutory Construction Act which provides that "no statute shall be construed to be retroactive unless clearly and manifestly so intended by the General Assembly." 1 Pa.C.S. § 1926.

Upon review of 18 Pa.C.S. § 4117(k)(1), there is no clear manifestation of intent that this statute be applied retroactively. *See e.g. Green v. Penn. Public Utility Comm.*, 81 Pa. Commw. 55, 473 A.2d 209 (Pa. Commw. 1984) (stating that there must be clear language in the statute before it will be given retroactive effect). Therefore, the Department's interpretation that 18 Pa.C.S. § 4117(k)(1) apply to forms which were already approved for use in the state of Pennsylvania would run afoul of the clear language of the Statutory Construction Act.

V. Consumer Complaints

The Company disagrees that there were 4 violations of the Unfair Insurance Practices Act relating to the Company's Complaint Log Report. The Department cites the Company for violations even though the Company provided the Department exactly what it asked for during the July 15, 2010 Data Call.

The Company Complaint Log Report provided to the Department on July 15, 2010 in response to the Data Call satisfied the requirements of 40 P.S. § 1171.5(a)(11) which defines an unfair trade practice as the:

> Failure of any person to maintain a complete record of all the complaints which it has 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*. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

(Emphasis added.)

The Company's practice is to maintain a record of each complaint received. This is accomplished utilizing a database which stores many data fields useful to the Company. The Company thus provides a Complaint Log Report which is a report based upon specific data fields extracted by the user. As such, any given report is limited to the data fields extracted from the database.

The Company's Complaint Log Report provided to the Department included the specific information requested by the Department in its July 15, 2010 Data Call which listed the following specific data fields: 1) Policy number, 2) Certificate number (if applicable), 3) Claim number, 4) First name of the complainant, 5) Last name of the complainant, 6) Date complaint received, 7) Reason for the complaint, 8) Date of initial complaint response, 9) Complaint resolution, and 10) Date complaint resolved. The Company's Complaint Log Report was an Excel spreadsheet with each row representing a complaint. The total number of complaints would equal the total number of rows on the complaint log, minus the row with labels. Therefore, the complaint log provided indicated the number of complaints.

Additionally, the Complaint Log Report provided to the Department indicated the time it took to process each complaint. Specifically, the Excel spreadsheet provided included both the date the complaint was received and the date the Company responded to the complaint. In order to ascertain how long it took to process a complaint, these two dates would only need to be compared.

As such, the Company should not be cited for violation of 40 P.S. § 1171.5(a)(11) because the information provided via the Company's Complaint Log Report indicated the total number of complaints and the time it took to process the complaint.

VII. B. Accident Claims Paid

The Company does not require claim forms before it begins handling a claim. Pennsylvania law defines notification of a claim as follows: "A notification, whether in writing, or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to the claim." 31 Penn. Code § 146.2. Pennsylvania law, therefore, recognizes that the terms of the insurance policy can determine what means are acceptable when notifying the Company of a claim. The Company has several policies pertinent to the issue at hand, however they all have similar language: "Notice of Claim: Written notice of claim must be given to us within 60 days after the occurrence of any loss covered by the policy, or as soon as it is reasonably possible. . ." FORM 39SD-1200. Therefore before the company can begin to investigate a claim, it must receive some written notice. Verbal notice, by itself, would be unacceptable and is insufficient notice of a claim under the policy language. The Company's practice is to accept any written notification of a claim that reasonably could put the Company on notice of a claim, regardless of whether formal claim forms have been submitted by the claimant.

Section 146.5. The Company asserts that it should be cited for only 4 violations of section 146.5. Pursuant to 31 Pa. Code § 146.5, the Company must fulfill, among other things, 2 obligations: 1) acknowledge receipt of a claim unless payment is made and 2) provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and requirements of the insurer.

Below are the Company's specific objections to the claim files referenced in the Exit Summary provided by the Department to the Company:

#12. The Company disagrees with the asserted violation. The claim file documentation supports that the Company received a request for claim forms on January 9, 2009. Claim forms were sent the same day. On April 7, 2009, the Company received notification of the claim via a Surgeon Letter regarding the insured. On April 15, 2009, the Company accepted the claim and rendered payment. Therefore, the Company acknowledged the claim, 6 working days after receiving notification of the claim.

#47. The Company disagrees with the asserted violation. The claim file documentation supports that the Company received a request for claim forms on July 10, 2009. Claim forms were sent the same day. Notification of this claim was received on August 12, 2009 via a doctor's statement. The Company acknowledged the claim and rendered payment on August 26, 2009, 10 working days after receiving notification of the claim.

#71. The Company disagrees with the asserted violation. The claim file documentation supports that the Company received a request for claim forms on January 14, 2009. Claim forms were sent to the claimant the same day. On March 24, 2009, the Company received notification of the claim via a hospital bill. On April 3, 2009, the Company acknowledged and paid the claim, 8 working days after receiving notification of the claim.

Section 146.6. The Company asserts that it should be cited for only 3 violations of section 146.6. Pursuant to 31 Pa. Code § 146.6, the Company is required to complete investigation of a claim within 30 days after receiving notification of a claim. If an investigation cannot be completed within 30 days, then the Company must provide the claimant with a reasonable written explanation for the delay and when a decision on the claim may be expected. The Company's practice is to send a status letter to the claimant when an investigation cannot be completed within 30 days indicating what additional information is needed before the claim can be processed. This status letter sets for the reason for the delay – that additional information is needed, and when a decision on the claim may be expected – as soon as the claimant sends the Company the requested information.

Below are the Company's specific objections to the claim files included in the Exit Summary provided by the Department to the Company:

#10. The Company disagrees with the asserted violation. The claim file documentation supports that on May 28, 2009, the Company received notification of the claim via a completed claim form. The Company completed its investigation on July 2, 2009, and mailed a letter indicating payment was made on the same day. Therefore the Company's handling of the claim was completed and communicated to the claimant 25 working days after receiving notification of the claim.

#12. The Company disagrees with the asserted violation. The claim file documentation supports that on April 7, 2009, the Company received notification of the claim via a Surgeon Letter regarding the insured. On April 15, 2009, the Company completed its investigation and mailed a letter indicating payment was made. Therefore, the Company's handling of the claim was completed and communicated to the claimant 6 working days after receiving notification of the claim.

#13. The Company disagrees with the asserted violation. The claim file documentation supports that on March 9, 2009, the Company received notification of the claim via a completed claim form and supporting documentation. The Company completed its investigation and paid the claim on April 17, 2009. Therefore, the Company's handling of the claim was completed and communicated to the claimant 29 working days after receiving notification of the claim.

#47. The Company disagrees with the asserted violation. The claim file documentation supports that on August 12, 2009, the Company received notification of this claim via a medical statement. On August 26, 2009, the Company completed its investigation and paid the claim. Therefore, the Company's handling of the claim was completed and communicated 10 working days after receiving notification of the claim.

#71. The Company disagrees with the asserted violation. The claim file documentation supports that the Company received notification of the claim via a hospital bill on March 24, 2009. On April 3, 2009, the Company completed its investigation and paid the claim, 8 working days after receiving notification of the claim.

Section 146.7. The Company asserts that it should be cited for only 11 violations of section 146.7. Pursuant to 31 Pa. Code § 146.7, the Company is required to accept or deny a claim, and advise the claimant of such, within 15 working days after receipt of properly executed proofs of loss. The Pennsylvania Administrative Code does not define the terms "properly executed proofs of loss." The Company's practice is to accept or deny a claim within 15 working days after receiving all information necessary to accept or deny the claim.

Below are the Company's specific objections to the claim files included in the Exit Summary provided by the Department to the Company:

#12. The Company disagrees with the facts above and asserted violation. The claim file documentation supports that on April 7, 2009, the Company received notification of the claim via a surgeon letter. On April 15, 2009, the Company accepted

the claim and rendered payment. Therefore, the Company paid the claim within 6 working days of proof of loss.

Unfair Insurance Practices Act. The Company disagrees that file #12 contains instances of non compliance. The Company disagrees that the violations found in 11 claim files constitute a violation of the Unfair Insurance Practices Act, 40 P.S. 1171.5(10). Pursuant to the Unfair Insurance Practices Act, in order for an act to constitute an unfair insurance practice, it must be "committed or performed with such a frequency as to indicate a business practice." Only 11 files contained instances of non compliance. This does not equate to being performed with such frequency to constitute a business practice. The Company views these instances of non-compliance as exceptions to its business practices.

VII. C. Accident Claims Denied

The Company disagrees that the violations found in 6 claim files constitute a violation of the Unfair Insurance Practices Act. Pursuant to the Unfair Insurance Practices Act, 40 P.S. 1171.5(10), in order for an act to constitute an unfair insurance practice, it must be "committed or performed with such a frequency as to indicate a business practice." Of the 29 files reviewed, only 6 files contained instances of non compliance. This does not equate to being performed with such frequency to constitute a business practice. The Company views these instances of non-compliance as exceptions to its business practice.

VII. D. Cancer Claims Paid

As stated above, the Company does not require claim forms before it begins handling a claim. Pennsylvania law defines notification of a claim as follows: "A notification, whether in writing, or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to the claim." 31 Penn. Code § 146.2. Pennsylvania law, therefore, recognizes that the terms of the insurance policy can determine what means are acceptable when notifying the Company of a claim. The Company has several policies pertinent to the issue at hand, however they all have similar language: Notice of Claim: "Written notice of claim must be given to us within 60 days after the occurrence of any loss covered by the policy, or as soon as it is reasonably possible. . ." FORM 39SD-1200. Therefore before the company can begin to investigate a claim, it must receive some written notice. Verbal notice, by itself, would be unacceptable and is insufficient notice of a claim under the policy language. The Company's practice is to accept any written notification of a claim that reasonably could put the Company on notice of a claim, regardless of whether formal claim forms have been submitted.

Section 146.7. The Company asserts it should be cited for only 7 violations of section 146.7. Pursuant to 31 Pa. Code § 146.7, the Company is required to accept or deny a claim, and advise the claimant of such, within 15 working days after receipt of

properly executed proofs of loss. The Pennsylvania Administrative Code does not define the terms "properly executed proofs of loss." The Company's practice is to accept or deny a claim within 15 working days after receiving all information necessary to accept or deny the claim.

Below are the Company's specific objections to the claim files included in the Exit Summary provided by the Department to the Company:

#46. The Company disagrees with the asserted violation. The claim file documentation supports that the Company received notification of the claim on January 22, 2009 via a completed claim form and pharmacy bills. On February 7, 2009, the Company sent a status letter to the claimant notifying her that the requested information regarding a non-chemotherapy drug treatment was required to process the claim. On February 28, 2009, the Company sent a second status letter requesting the information regarding the non-chemotherapy drug treatment. On March 14, 2009, the Company sent a final status letter indicating that the claim was being closed for not receiving the requesting information. On April 28, 2009 the requisite information was received to complete the claim including the medical questionnaire and pathology report. The Company accepted the claim and rendered payment on May 12, 2009, 10 working days after receiving a complete proof of loss.

#68. The Company disagrees with the asserted violation. The claim file documentation supports that the Company received notification of the claim via a completed claim form on May 6, 2009. On May 8, 2009, the Company mailed a status letter to the claimant requesting the required proof of loss to process the claim including a pathology report. On May 21, 2009, the claimant sent in the complete proof of loss including the pathology report. The Company accepted the claim and rendered payment on May 29, 2009, 5 working days after receiving a complete proof of loss.

#97. The Company disagrees with the asserted violation. The claim file documentation supports that the Company received notification of the claim and a complete proof of loss on December 9, 2008 when it received medical records regarding the claim. The Company accepted the claim and rendered payment on January 2, 2009, 15 working days after receiving proof of loss.

Unfair Insurance Practices Act. The Company disagrees that files #46, 68 and 97 contain instances of non compliance. The Company disagrees that the violations found in 7 claim files constitute a violation of the Unfair Insurance Practices Act, 40 P.S. 1171.5(10). Pursuant to the Unfair Insurance Practices Act, in order for an act to constitute an unfair insurance practice, it must be "committed or performed with such a frequency as to indicate a business practice." Only 7 files contained instances of non compliance. This does not equate to being performed with such frequency to constitute a business practice. The Company views these instances of non-compliance as exceptions to its business practices.

VII. F. Cancer Claims Denied

Section 146.5. The Company disagrees that there are 9 violations of 31 Pa. Code § 146.5. Pursuant to 31 Pa. Code § 146.5, the Company must fulfill, among other things, 2 obligations: 1) acknowledge receipt of a claim unless payment is made, and 2) provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and requirements of the insurer.

In the Preliminary Initial Summary, the Department cited the Company for 8 violations. The Company responded to the Department with the following fact pattern regarding file #11:

#11-[REDACTED]; disagree with violation
This claim originated from claim [REDACTED]

- *8/21/09 - proof of claim received*
- *9/3/09 - letter sent acknowledging claim and requesting additional information (9 working days)*
- *9/24/09- 2nd request letter sent on (15 working days). No response received*
- *10/8/09 -3rd letter sent*

This information was in the claim file provided

Based upon the above fact pattern, notification of the claim was received on August 21, 2009 and the claim was acknowledged on September 3, 2009, 9 working days later.

In the Exit Initial Summary, the Department added a violation citing file #14 of the denied cancer claims reviewed (hereinafter referred to as "file #14"). The Company had no opportunity to provide a formal response to the asserted violation. As such, the Company asserts there is no violation of #14. Section 146.5 is only triggered under 2 circumstances: 1) when there is notification of a claim and 2) when the Company has received an inquiry regarding the claim from the Department. The former applies here. The claim file documentation shows that notification of the claim was received on October 22, 2009 and the claim was denied on November 2, 2009, only 7 working days later.

The Company therefore asserts that only 7 instances of non-compliance exist.

Section 146.6. The Company disagrees that there are 5 violations of 31 Pa. Code § 146.6. Pursuant to 31 Pa. Code § 146.6, the Company is requires to complete investigation of a claim within 30 days after receiving notification of a claim. If an investigation cannot be completed within 30 days, then the Company must provide the claimant with a reasonable written explanation for the delay and when a decision on the claim may be expected. The Company's practice is to send a status letter to the claimant when an investigation cannot be completed within 30 days indicating what additional information is needed before the claim can be processed. This status letter sets for the

reason for the delay – that additional information is needed, and when a decision on the claim may be expected – as soon as the claimant sends the Company the requested information.

In the Preliminary Initial Summary, the Department cited the Company for 4 violations. The Company responded with the following fact pattern for file #11:

#11-[REDACTED]; disagree with violation
This claim originated from claim [REDACTED]

- *8/21/09- proof of claim received*
- *9/3/09 - letter sent acknowledging claim and requesting additional information (9 working days)*
- *9/24/09 - 2nd request letter sent (15 working days). No response received*
- *10/5/09 - claim information received*
- *10/8/09 - 3rd request letter sent; claim documents received on 10/5/09 but in queue awaiting processing*
- *10/9/09 - claim processed (4 working days from receipt of requested information)*

This information was in the claim file provided.

Based upon the fact pattern above, the Company received notification of the claim on August 21, 2009. The investigation could not be completed without the additional information which was requested on September 3, 2009, 9 working days later. The Company provided the claimant with a written explanation for the delay – i.e. that additional information was required to process the claim. The Company received the final claim documentation on October 5, 2009, and the claim was denied on October 9, 2009, 4 working days later. As such, the claim investigation could not be completed within 30 days, so the Company send a letter to the claimant explaining why only 9 working days after receiving notice of the claim.

In the Exit Initial Summary, the Department added a violation citing file #14. The Company had no opportunity to provide a formal response to the asserted violation. As such, the Company asserts there is no violation of #14. Section 146.6 requires that the Company complete investigation of a claim within 30 days after receiving notification of the claim. The claim file documentation shows that notification of the claim was received on October 22, 2009 and the claim was denied on November 2, 2009, only 7 working days later.

The Company therefore asserts that only 3 instances of non-compliance exist.

Section 146.7. The Company disagrees that there are 5 violations of 31 Pa. Code § 146.7. Pursuant to 31 Pa. Code § 146.7, the Company is required to accept or deny a claim, and advise the claimant of such, within 15 working days after receipt of properly executed proofs of loss. The Pennsylvania Administrative Code does not define the terms

"properly executed proofs of loss." The Company's practice is to accept or deny a claim within 15 working days after receiving all information necessary to accept or deny the claim.

In the Preliminary Initial Summary, the Department cited the Company for 6 violations. The Company responded to the Department with the following fact pattern for file #11:

#11-[REDACTED]; disagree with violation
This claim originated from claim [REDACTED]

- *8/21/09- proof of claim received*
- *9/3/09 - letter sent acknowledging claim and requesting additional information (9 working days)*
- *9/24/09 - 2nd request letter sent (15 working days). No response received*
- *10/5/09 - claim information received*
- *10/8/09 - 3rd request letter sent; claim documents received on 10/5/09 but in queue awaiting processing*
- *10/9/09 - claim processed (4 working days from receipt of requested information)*

This information was in the claim file provided.

Based upon the fact pattern above, the Company received notification of the claim on August 21, 2009. On September 3, 2009, 9 working days later, the Company notified the claimant that before the claim could be processed additional information regarding the proof of loss was required. The Company then advised the claimant what additional information was required. The Company received the properly executed proofs of loss for the claim on October 5, 2009 and the claim was denied on October 9, 2009, 4 working days later. Therefore the Company complied with section 146.7 by denying the claim within 4 working days after receiving a complete proof of loss.

In the Exit Initial Summary, the Department added a violation citing file #14. The Company had no opportunity to provide a formal response to the asserted violation. As such, the Company asserts there is no violation of #14. Section 146.7 requires the Company to advise the claimant that the claim is accepted or denied within 15 working days after receipt by the Company of a complete proof of loss. The claim file documentation shows that a complete proof of loss was received on October 22, 2009 and the claimant was advised that the claim was denied on November 2, 2009, 7 working days after receiving a complete proof of loss.

The Company therefore asserts that only 4 instances of non-compliance exist.

VII. G. Heart Stroke Claims Paid

The Company disagrees that the instances of non compliance found in 2 claim files constitute a violation of the Unfair Insurance Practices Act, 40 P.S. 1171.5(10). Pursuant to the Unfair Insurance Practices Act, in order for an act to constitute an unfair insurance practice, it must be "committed or performed with such a frequency as to indicate a business practice." Of the 9 files reviewed only 2 files contained instances of non compliance. This does not equate to being performed with such frequency to constitute a business practice. The Company views these instances of non-compliance as exceptions to its business practices.

VII. K. Medicare Supplement Insurance Claims Paid

Section 146.5. The Company asserts that it should be cited for only 4 violations of section 146.5. Pursuant to 31 Pa. Code § 146.5, the Company must fulfill, among other things, 2 obligations: 1) acknowledge receipt of a claim unless payment is made, and 2) provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and requirements of the insurer.

In the Preliminary Initial Summary, the Department cited the Company for 7 violations but removed #76. The Company's response to the Preliminary Initial Summary concerning files #14 and 36 stated as follows:

> *#14-Claim received date 2/16/09 – paid date 3/2/09 is equal to 10 working days*
>
> *#36-Claim received date 2/16/09 – paid date 3/2/09 is equal to 10 working days*

Section 146.5 requires that the Company acknowledge receipt of the claim unless payment is made within 10 working days. As the file documentation supports, both files were paid 10 working days after receiving notification of the claim.

The Company therefore asserts that only 4 instances of non-compliance exist.

VIII. Recommendations

The Company disagrees that corrective measures are necessary because the instances of non-compliance amount to a small percentage of the files reviewed. As such, any instances of non-compliance are an exception to the Company's normal business practice of handling claims in a reasonable and timely fashion.

The Company, however, will agree to do the following:

1. The Company will adhere to 18 Pa. Code § 4117(k)(1), by ensuring that all forms hereinafter filed with the Department will contain the requisite fraud warning.

2. The Company already has practices in place to ensure compliance with 40 P.S. § 1171.5.

3. The Company will review internal control procedures with its claims Department to address any compliance concerns regarding 31 Pa. Code § 146 et al.

Conclusion

We appreciate the opportunity to provide this response. If you have any questions, please feel free to contact me directly at 317-817-5638 or lisa.harpenau@cnoinc.com.

Regards,

Lisa Harpenau

cc: Christopher Monahan via email only