



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

**MARKET CONDUCT
EXAMINATION REPORT**

OF

**FIRST PRIORITY LIFE
INSURANCE COMPANY**
Wilkes-Barre, PA

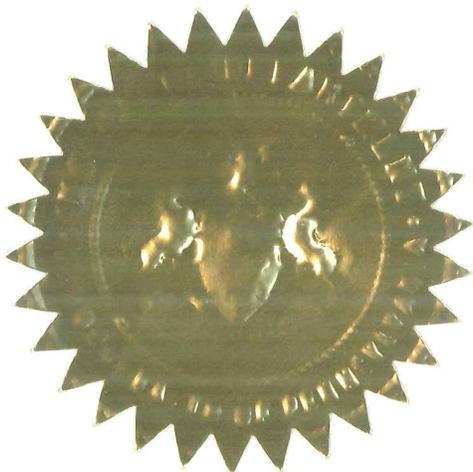
As of: JUNE 26, 2013
Issued: AUGUST 8, 2013

**BUREAU OF MARKET ACTIONS
LIFE AND HEALTH DIVISION**

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

First Priority Life Insurance Company
Market Conduct Re-Examination as of
the close of business on August 8, 2013

Docket No.
MC13-08-006

ORDER

A market conduct examination of First Priority Life Insurance Company (referred to herein as the “Respondent”) was conducted in the offices of the Respondent covering the period from January 1, 2008 to December 31, 2008. This examination was resolved through a Consent Order dated February 1, 2011. Contemporaneously with the execution of the Consent Order, an Examination Report was issued to the Respondent. The Consent Order called for a re-examination to be conducted by the Department after a period of 18 months from the effective date of the Consent Order to determine the Respondent’s compliance with the recommendations included in the Examination Report.

In accordance with the terms in the Consent Order, a market conduct re-examination of the Respondent was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. §323.1, et seq., for the period August 1, 2011, through July 31, 2012. Based on the documentation and information submitted by the Respondent during the re-examination, the Department is satisfied that the Respondent has taken corrective measures pursuant to the recommendations of the Examination

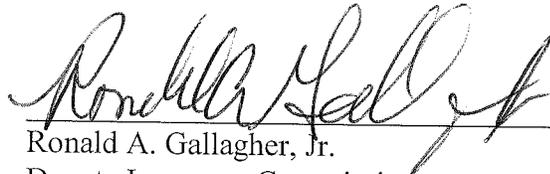
Report and that its findings discovered during the re-examination fall within an acceptable range of findings based on NAIC claim payment standards.

It is hereby ordered as follows:

1. The attached Re-Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Re-Examination Report and related documents are contained in the attached Re-Examination Report.
2. Respondent shall comply with Pennsylvania statutes and regulations.
3. Respondent shall comply with all recommendations contained in the attached Report.
4. 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.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. §323.5), will continue to hold the content of the Re-Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

BY: The Pennsylvania Insurance Department



Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

August 8, 2013

FIRST PRIORITY LIFE INSURANCE COMPANY

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I. INTRODUCTION

The Market Conduct Examination was conducted on First Priority Life Insurance Company, hereafter referred to as “Company,” at the Company’s office located in Wilkes Barre, Pennsylvania starting on January 28, 2013, through June 20, 2013. In addition to the Wilkes Barre location, a portion of the examination was conducted at the offices of the Company’s vendor on April 9 and 10, 2013. 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 following examiners participated in the Examination and in the preparation of this Report.

Yonise A. Roberts Paige, MCM
Market Conduct Division Chief

Gary L. Boose, LUTC, MCM
Market Conduct Examiner

Wanda M. LaPrath, CFE, CIE, MCM, FLMI, ARC
President, The Huff Group

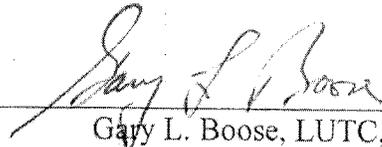
Jenny Jeffers, CISA, AES
IT Specialist

Joseph S. Krug, CPA, AFE
Market Conduct Examiner

Thomas W. Jones, AIE, AIRC, CCP, CLCR, MCM
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).



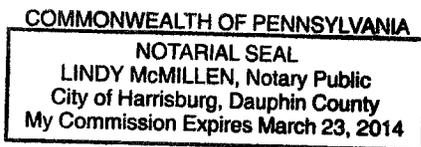
Gary L. Boose, LUTC, MCM

Sworn to and Subscribed Before me

This 21st Day of June, 2013



Notary Public



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 from August 1, 2011, through July 31, 2012. The purpose of the re-examination was to ensure compliance with Pennsylvania insurance laws and regulations including recommendations communicated to the Company in the Market Conduct Examination Report dated February 1, 2011.

The scope of the examination includes, but is not limited to, the Company's activities relating to the implementation of a corrective action plan. The examination also included an informational technology review of the Company's claims systems and related processes.

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 incorporated on July 15, 1997, under the name of Eastern American Life Insurance Company, Inc., as a wholly-owned subsidiary of Hospital Service Association of Northeastern Pennsylvania, d/b/a Blue Cross of Northeastern Pennsylvania (HSA). The Company was primarily formed to market and administer a non-gatekeeper preferred provider organization product to be marketed as First Point.

On December 30, 1997, the Company filed an amendment to its Articles of Incorporation to change its name to First Priority Life Insurance Company, Inc.

Effective August 18, 1998, the Company was issued a Certificate of Authority to issue policies and otherwise transact the business of insurance in the Commonwealth of Pennsylvania under Section 202, subdivision (a), Paragraphs (1) Life and Annuities, and (2) Accident and Health, of the Act of May 17, 1921, as amended, (40 P.S. § 382) in accordance with its Charter and the Laws of the Commonwealth of Pennsylvania.

On April 29, 2005, Blue Cross of Northeastern Pennsylvania sold a 40% minority interest of the Company to Highmark Inc.

The Company commenced business selling a Preferred Provider Organization (PPO) product, BlueCare Qualified High Deductible, November 6, 2006. The Company is currently selling both group and individual PPO products and commenced selling an Exclusive provider Organization (EPO) product in 2008.

The Company's total Pennsylvania earned premium, as reported in their 2011 Annual Statement, was \$380,396,930. The total annual member months was reported as 993,443.

IV. CLAIMS MANUAL & CLAIMS

A. Claims Manual

The Company was requested to provide copies of all procedural guidelines used in handling claims during the experience period including: all training manuals, internal audit examination manuals, Company memoranda and any other instructions concerning claims handling. The Company provided the following claims manuals:

1. OSCAR Claims Processing Manual
 - Claims Forms Overview
 - Preference – Online Manuals
 - Health Care Codes System
 - Other Insurance
 - Benefits
 - Pennsylvania State Mandates
 - Pricing
 - Managed care
 - OCWA (OSCAR Claims Web Application)
 - Accumulations - Inquiry
 - Claim – Inquiry
 - Customer Control Tables (CCT) Inquiry
 - Development Text Codes - Inquiry
 - Group (Client) – Inquiry
 - Inventory Workflow Management
 - Member – Inquiry
 - Provider - Inquiry
 - Concurrent Processing

2. Claims Administration – Quality Assurance Program

- Mission/Purpose/Goals/Objective
- Audit Scope
- Roles And Responsibilities
- Performance Measures
- Review Process
- Reporting

3. Claims Processing Daily Updates

The claims manuals and procedural guidelines were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

B. Information Technology Review

The Company was requested to provide a list of all data systems information methodologies used as well as third party administrators (TPA) methods and usage utilized during the experience period. The Company provided all methods as well as their third party administrator's methodologies. All data section systems information was requested, received and reviewed. The information was reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices and Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. No violations were noted in this section of the examination.

Department Concern: The Department requested the Company to provide claims data based on receipt date for Pennsylvania residents. The claims data was provided to the Department inaccurately on two occasions. On the first occasion, the data was provided

as a finalized claim data report and included both Pennsylvania and non-Pennsylvania residents. On the second occasion, the data was provided based on receipt date for Pennsylvania residents; however, discrepancies occurred in which some claims were dropped and not reported. The Company provided an explanation that referenced a system migration, an issue with the joiner between two systems, the application of the wrong date for extraction of the data report and adjustments made during the experience period that contributed to the inaccuracy of data. The incomplete and inaccurate data provided to the Pennsylvania Insurance Department directly affected the testing and review of the claim sections of the examination. The Department is concerned that the system migration and the multiple data warehouses utilized for record retention has compromised the testing of claims.

In addition, the Department noted issues with the Company's informational technology system(s) which impacted the adjudication of claims during the experience period. There were some claims from 2006 to 2012 in which the company reprocessed these claims during the experience period and either paid or denied the claims. The Company utilizes the vendor's Software A for the adjudication process of claims received. The vendor's Software B system is utilized to issue check payments, Explanations of Benefits (EOB), and Explanations of Reason (EOR). It was noted claims are denoted as "finalized" in the Software A system but are not promptly processed by Software B as Software B imposes additional criteria. The additional criteria have resulted in delays to complete the processing of both paid and denied claims.

The Department also noted that controls relating to the testing of modifications to the Company's claims processing systems were inadequate. Modifications to the systems affecting the Company's claims processing should include sufficient testing by the vendor to limit issues remaining prior to the Company's testing, sufficient subsequent user acceptance testing to provide high assurance of correct functionality, and control by the Company's user acceptance testers as to when system modifications are to be

implemented. The Service Level Agreements between the Company and the vendor should be tightened to ensure these steps occur, and the Company should actively monitor its vendor to ensure services provided meet the Service Level Agreements.

C. Provider Submitted Clean Claims Paid Over 45 Days

The Company was requested to provide a list of all provider submitted clean claims paid over 45 days received during the experience period. The Company identified a universe of 14,268 provider submitted clean claims paid over 45 days. A random sample of 150 provider submitted clean claims paid over 45 days was requested, received and reviewed. The claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. The following violation was noted:

1 Violation – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

D. Provider Submitted Emergency Room Claims

The Company was requested to provide a list of all provider submitted emergency room claims denied during the experience period of August 1, 2011 through July 31, 2012. The Company identified a universe of 3,018 provider submitted emergency room claims denied. A random sample of 100 provider submitted emergency room claims denied was requested, received and reviewed. The claim files were reviewed for compliance with

Insurance Company Law of 1921, Section 2166 (40 P.S.§991.2166) Prompt Payment of Claims. No violations were noted.

The following table shows a brief synopsis for the 100 denied files:

Number	Reasons for Denial	%
45	Duplicate Claim	45%
16	Coverage Not in Effect	16%
12	Additional Information Required	12%
10	Service is Not Covered	10%
6	Exceeded Time Limit for Filing	6%
6	Medicare Claim	6%
5	Worker's Compensation Claim	5%
100	TOTAL	100%

E. Provider Submitted Clean Claims Denied Over 45 Days

The Company was requested to provide a list of all clean claims denied over 45 days received during the experience period. The Company identified a universe of 3,534 clean claims denied over 45 days. A random sample of 100 clean claims denied over 45 days was requested, received and reviewed. The claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. No violations were noted.

The following table shows a brief synopsis for the 100 denied files:

Number	Reasons for Denial	%
31	Billing Error	31%
25	Duplicate Claim	25%
18	Additional Information Required	18%
16	Coverage Not in Effect	16%
3	Medicare Claim	3%
3	Out-of-Network	3%
2	Worker's Compensation Claim	2%
1	Automobile Insurance Claim	1%
1	Exceeded Time Limit for Filing Claim	1%
100	Total	100%

F. Provider Submitted Mammography Claims Denied Under Age of 40

The Company was requested to provide a list of all provider submitted mammography claims denied under age 40 during the experience period. The Company identified a universe of 31 provider submitted mammography claims denied under age of 40. All 31 provider submitted mammography claims denied under age 40 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. No violations were noted.

The following table shows a brief synopsis for the 31 denied files:

Number	Reasons for Denial	%
12	Duplicate Claim	38%
10	Additional Information Required	33%
4	Out-of-Network	13%
3	Billing Error	10%
1	Service Not Covered	3%
1	Exceeded Time Limit for Filing Claim	3%
31	Total	100%

G. Mammography Claims Denied

The Company was requested to provide a list of all mammography claims denied received during the experience period. The Company identified a universe of 961 mammography claims denied. A random sample of 50 mammography claims denied all 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. No violations were noted.

The following table shows a brief synopsis for the 50 denied files:

Number	Reasons for Denial	%
33	Duplicate Claim	66%
7	Out-of-Network	14%
5	Provider Billing Error	10%
2	Coverage Not in Effect	4%
2	Exceeded Time Limit	4%
1	Pre-existing Condition	2%
50	TOTAL	100%

H. Out-of-Area Provider Submitted Claims

The Company was requested to provide a list of all clean medical and emergency provider submitted claims paid over 45 days from the date of receipt of the proof of loss, during the experience period for Section G. During the review of the claim files from Section G, it was noted nine (9) claim files were initially denied and were subsequently paid or denied under a different claim number with a different received date. Additionally, the claim files were all out-of-area provider submitted claims. Of these nine (9) claims, no Explanation of Benefits (EOB) was generated on five (5) claims. Upon additional review and discussions with Company personnel, it was determined each

of the claims had been denied and were then subsequently resubmitted by the provider and/or Host Plan. The five (5) denied claims for which no EOBs were generated involved Inter-Plan Teleprocessing Systems (ITS) claims subject to processing under Blue Cross Blue Shield Association procedures. No violations were noted.

I. Discretionary Sub-Sample of Clean Claims Paid Over 45 Days

The Company was requested to provide a list of clean claims received during the experience period. The Company identified a universe of 17,802 provider submitted clean claims for which processing (paid or denied) exceeded 45 days. Of the total, it was noted there were 272 clean claims processed (paid or denied) for which no adjustments were reported. A discretionary sample of 16 paid provider submitted clean claims for which processing exceeded 365 days was requested, received and reviewed. The claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. The following violations were noted:

10 Violations – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

- (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. There were 10 noted clean claims which were not paid within 45 days of receipt.

Department Concern: Based on the review of this discretionary sample, the Company has demonstrated that they have inadequately monitored their third party administrator (TPA) during the experience period to ensure that the claims were processed in a timely manner and in accordance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

It should also be noted that, neither the Company or its TPA had a manual process in place to generate payments, EOBs, or EORs during the experience period to ensure compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims when the connection between the automated claims system and check-writing systems failed.

J. Subscriber Submitted Medical Insurance Claims

The Company was requested to provide a list of subscriber submitted medical insurance claims received during the experience period. The Company reported to the Pennsylvania Insurance Department there were no subscriber submitted medical insurance claims received or finalized during the experience period. Therefore, there were no subscriber submitted medical insurance claims files to be reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 –Unfair Insurance Practices. No files were reviewed.

K. Subscriber Submitted Emergency Room Claims Denied

The Company was requested to provide a list of emergency room claims denied during the experience period. The Company reported to the Pennsylvania Insurance Department there were no subscriber submitted emergency room claims received or finalized during the experience period. Therefore, there were no subscriber submitted emergency room denied claim files to be reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices. No files were reviewed.

V. 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 prompt payment of claims of Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims (A)(B).

VI. COMPANY RESPONSE

July 19, 2013

Ms. Yonise Roberts Paige, Chief
Life, Accident and Health Division
Pennsylvania Insurance Department
Market Action Bureau
1321 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 12-M25-047
First Priority Life Insurance Company (d/b/a First Priority Life)

Dear Ms. Paige:

This letter is in response to your Report of Examination received on June 26, 2013, regarding the Pennsylvania Insurance Department's ("Department's") Market Conduct Examination of First Priority Life Insurance Company (d/b/a, First Priority Life ("FPLIC")) covering the period of August 1, 2011 through July 31, 2012, as of the close of business on June 20, 2013.

Thank you for the opportunity to review the Department's Report of Examination. We have reviewed the report and find the information noted within to be helpful in improving our processes. Listed below are First Priority Life's responses to the concerns and recommendations made by the Department:

1. Section IV.B – Information Technology Review:

Department Concern

The Department requested the Company to provide claims data based on receipt date for Pennsylvania residents. The claims data was provided to the Department inaccurately on two occasions. On the first occasion, the data was provided as a finalized claim data report and included both Pennsylvania and non-Pennsylvania residents. On the second occasion, the data was provided based on receipt date for Pennsylvania residents; however, discrepancies occurred in which some claims were dropped and not reported. The Company provided an explanation that referenced a system migration, an issue with the joinder between two systems, the application of the wrong date for extraction of the data report and adjustments made during the experience period that contributed to the inaccuracy of data. The

incomplete and inaccurate data provided to the Pennsylvania Insurance Department directly affected the testing and review of the claim sections of the examination. The Department is concerned that the system migration and the multiple data warehouses utilized for record retention has compromised the testing of claims.

In addition, the Department noted issues with the Company's informational technology system(s) which impacted the adjudication of claims during the experience period. There were some claims from 2006 to 2012 in which the company reprocessed these claims during the experience period and either paid or denied the claims. The Company utilizes the vendor's Software A for the adjudication process of claims received. The vendor's Software B system is utilized to issue check payments, Explanations of Benefits (EOB), and Explanations of Reason (EOR). It was noted claims are denoted as "finalized" in the Software A system but are not promptly processed by Software B as Software B imposes additional criteria. The additional criteria have resulted in delays to complete the processing of both paid and denied claims.

The Department also noted that controls relating to the testing of modifications to the Company's claims processing systems were inadequate. Modifications to the systems affecting the Company's claims processing should include sufficient testing by the vendor to limit issues remaining prior to the Company's testing, sufficient subsequent user acceptance testing to provide high assurance of correct functionality, and control by the Company's user acceptance testers as to when system modifications are to be implemented. The Service Level Agreements between the Company and the vendor should be tightened to ensure these steps occur, and the Company should actively monitor its vendor to ensure services provided meet the Service Level Agreements.

First Priority Life Response

First Priority Life acknowledges the Department's concern with the reports provided to the Department. The Company believes this was an isolated issue and does not occur with the various reports that are used for daily operations. There was confusion as to the information being sought by the Department involving all parties and with regard to the type of files being requested (finalized / received). This appears to have created a circumstance in which the Department received two different files from different systems.

The Company also acknowledges the Department's concern regarding the transition of some claims between the claims processing system and reimbursement/notification system. First Priority Life identified the issue in July 2012 through a regular claims review. Claims were corrected and a manual process was implemented that requires a routine review of all claim inventory locations. The identification of the issue and the corrective actions were initiated in July 2012, prior to receiving the Department's notifications of the Market Conduct Examination (November 2012). The Company is working diligently with the vendor to have the system issue corrected and to resolve the issues raised by the Department

The Company acknowledges the Department's concern around testing of system modifications. The Company would like to note that we do have a formal testing process in place, whereby our system vendor provides us with the business requirements, test plans and testing results for all systems modifications / Change Requests that impact the Company.

First Priority Life routinely reviews and modifies the Performance Standards included in the Service Level Agreement with its vendor. A Joint Operating Committee attended by Company and vendor representatives meets regularly to address performance issues. Additionally, the Company's Vice President of Information Technology frequently meets with the vendor's Chief Information Officer to discuss any system issues and elevate any issues if necessary.

To that end, the Company will use the results of this audit to revisit the Service Level Agreement and address any performance issues with our vendor.

2. *Section IV.I – Discretionary Sub-Sample of Clean Claims Paid Over 45 Days*

Department Concern

Based on the review of this discretionary sample, the Company has demonstrated that they have inadequately monitored their third party administrator (TPA) during the experience period to ensure that the claims were processed in a timely manner and in accordance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

It should also be noted that neither the Company nor its TPA had a manual process in place to generate payments, EOBs, or EORs during the experience period to ensure compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims when the connection between the automated claims system and check-writing systems failed.

First Priority Life Response

The Company acknowledges the Department's concern. First Priority Life would like to note that we identified the issue in July 2012 through a regular claims review. Claims were corrected and a control was implemented that expanded our daily review of claim inventories to include finalized locations.

The identification of the issue and the corrective actions were initiated in July 2012, prior to receiving the Department's notifications of the Market Conduct Examination (November 2012). A manual process to pay the claims and generate EOBs / EORs was also implemented in July 2012.

The Company would also like to note that the concern and violations identified in this section were a result of a focused audit. Based on sampling standards, an audit based upon a non-random sample is only informative as to the sample drawn and should not be extrapolated to the larger population of claim files represented in the audit period.

We take pride in our claims processing performance, as evidenced by data indicating that 99.91% of claims were processed within 45 days in 2012.

Lastly, the Company would like to note that the Company actively monitors our vendor's performance through a variety of methods, including:

- regularly scheduled Joint Operating Committee meetings between Company representatives and vendor representative to review and revise agreement standards.
- weekly meeting between Claims' management and the vendor's Partner Plan Client Manager. High priority issues, including system issues, as well as new initiatives, software releases, etc. are discussed.
- monthly "CIO Meeting" that includes both CIOs from the Company and our vendor as well as Claims and other personnel. At this meeting, the vendor's performance in relation to systems performance/availability, data center,

Ms. Yonise Roberts Paige
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July 19, 2013

system change requests and release status, and the Service Level Agreement (SLA) results are reviewed.

- bi-weekly meeting between the vendor and BCNEPA where the top system-related priorities are monitored and reviewed until they are resolved.

3. Section V – Recommendations:

Department Recommendation

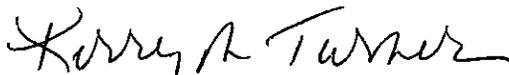
The Company must implement procedures to ensure compliance with the prompt payment of claims of Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims (A)(B).

First Priority Life Response:

First Priority Life acknowledges the Department's recommendation and will take it into consideration when reviewing our procedures and claims processing guidelines to ensure that all claims are processed in accordance with the Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

We would like to thank you and your staff for the courtesy and cooperation extended to us during this exam. If you have any questions or require additional information, please contact me at (570) 200-4421 or Kerry.Turner@bcnepa.com. Thank you.

Sincerely,



Kerry M. Turner
Vice President, Corporate Assurance & Compliance

cc: Denise S. Cesare, President & Chief Executive Officer
Brian J. Rinker, Sr. Vice President - Chief Administrative Officer